MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

920 07723

CERTIFICATE OF DEATH

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs
Hospital, institution or street address where death occurred: St Gabriel Nursing Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Baltimore
City or town Catonsville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 27 N. Carey St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Geraldine Ahlas

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife ✓
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) May 12th 1932

8. AGE: Years	Months	Days	If less than one day
15	4		... hrs. ... min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual occupation School Girl
11. Industry or business

FATHER
12. Name John A. Ahlas
13. Birthplace Wilmington Delaware

MOTHER
14. Maiden name Genevieve Wicker
15. Birthplace Baltimore Md

16. Informant Mr John Ahlas
Address 27 N. Carey St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/15/47 (month) (day) (year)
Cemetery or crematory Loudon Park Cem.
Location 3801 Frederick Ave
18. Funeral director John J. Coyle & Son
Address 910-03 Holland St

19. 9/12 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11th 1947 at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Acute Cardiac Failure	
Due to Valvular heart disease	
Due to Rheumatic heart	
Other conditions	

(Include pregnancy within 8 months of death)

Major findings of operations ... Date of op. ...
Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE Geo M Kieffer for Evelyn H Bulla M. D. or other
Address 1010 Leadenhall Date signed 9-11-47

Kept Med.

Evidence for the change of birthplace is shown on Film G113

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13 1a

07725

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 yrs. 25 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 19 yrs. 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Hyde (?)

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Unknown

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

Bakie, Sarah Jane

3. (b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Female	White	Widowed

8.(b) Name of husband or wife: John R. Bakie (deceased)

8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1874

8. AGE: Years	Months	Days	If less than one day
73			hrs. min.

9. Birthplace: Edgewood, Maryland (Town, county, and state)

10. Usual occupation: Unknown.

11. Industry or business: Unknown.

FATHER

12. Name: Unknown.

13. Birthplace

MOTHER

14. Maiden name: Unknown.

15. Birthplace

16. Informant: Hospital Records.

Address: Catonsville, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 1 /47. (month) (day) (year)

Cemetery or crematory: St. John's

Location: Ellicott City, Md.

18. Funeral director: Harry H. Mitzle

Address: 4101 Edmondson Ave.

19. 10/7 1947 (Date rec'd by registrar) J.C. Nunnemacher Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 29 19 47 at 4:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 4, 19 28, to September 29, 19 47 and that I last saw h... alive on September 29, 19 47

Immediate cause of death	DURATION
(a) Chronic lateral sclerosis	6 mos.
Due to (b) Chronic art. Sclerotic C.V.R. disease	Indef.
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other

Address: Spring Grove State Hospital Date signed: 9-29-47

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information correctly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

10/7/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07724

164c

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH

County: Baltimore Co

City or town: Catonsville Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs

Hospital, institution, or street address where death occurred: Powers Lane

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street, No.: Powers Lane

(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3. (a) FULL NAME: Roy Allen Barkley

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	Married

6.(b) Name of husband or wife: Beulah Barkley

6.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): June 18 1911

8. AGE: Years	Months	Days	If less than one day
36	7	19	..... hrs. ..... min.

9. Birthplace: W Va

(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Mine

FATHER 12. Name: Cecil Barkley

13. Birthplace: W Va

MOTHER 14. Maiden name: Esther Simmons

15. Birthplace: W Va

16. Informant: Beulah Barkley

Address: Powers Lane

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/14/47 (month) (day) (year)

Cemetery or crematory: Oliver Cemetery

Location: Cass W Va

18. Funeral director: Edgar L. MacNabb

Address: Catonsville Md.

19. 9-16 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 8 1947 at 11-48 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Gun shot wound of head

	DURATION
Due to:	
Due to:	
Other conditions: Suicide	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of: Sept 8 1947

Where did injury occur? Catonsville (City or town) Baltimore (County) Md. (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Shot himself with gun Injured at work? No

23. SIGNATURE: Geo. W. Kieffer Capt Med Res M. D. or other

Address: 1015 Leeds Ave Date signed: Sept 10 1947

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

B 07738

Reg. Dist. No. 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: BALTIMORE
City or town: TOWSON
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
SHEPPARD AND ENOCH PRATT HOSPITAL
How long in hospital or institution? SINCE Feb 17, 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: OHIO County:
City or town: VAN WERT
(If outside city or town limits, write RURAL and give nearest town)
Street No.: P.O. Box 146
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3. (a) FULL NAME: LEE Richie BONNEWITZ

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	Widowed

6.(b) Name of husband or wife: NELLIE TOWEY
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 21, 1867

8. AGE: Years	Months	Days	If less than one day
80	5	26	hrs. min.

9. Birthplace: CONVOY, VAN WERT COUNTY, OHIO (Town, county, and state)
10. Usual occupation: FARMER
11. Industry or business: Seed and Corn business

FATHER
12. Name: David Rhodes BONNEWITZ
13. Birthplace: PENNA.

MOTHER
14. Maiden name: CATHERINE Richie
15. Birthplace: OHIO

16. Informant: HOSPITAL RECORDS (Sheppard-Pra)
Address: Towson, Balto. Co. Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Sept. 28 1947 (month) (day) (year)
Cemetery or crematory: Woodland
Location: Van Wert, Ohio

18. Funeral director: Harry H Withe Jr
Address: 410 Edmondson Ave

19. 9/28 1947 (Date rec'd by registrar) A.M. Bacon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 27 1947 at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 17, 1945 to Sept. 27 1947 and that I last saw h...[illegible] alive on Sept. 27 1947

Immediate cause of death	DURATION
Due to: Chronic Myocarditis and Myocardial degeneration	
Due to: Generalized Arteriosclerosis	
Other conditions: Senile Psychosis (10/3/47)	9 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W.W. Elgin
W.W. Elgin, M.D. M. D. or other
Address: Towson 4, Md. Date signed Sept 27, 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07729

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County: Baltimore

City or town: Reisterstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 48 yrs

Hospital, institution, or street address where death occurred: Oakland Mills Rd Reisterstown Md

How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Reisterstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Oakland Mills Road

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Mary Emma Vaughn Bowers

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife: George Washington Bowers

6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): September 23 1869

8. AGE: Years 77 | Months 11 | Days 30 | If less than one day: hrs. min.

9. Birthplace: North Branch Baltimore Co Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: -

FATHER — 12. Name: John P Vaughn

13. Birthplace: Balto Co Md

MOTHER — 14. Maiden name: Margaret Parker

15. Birthplace: Balto Co Md

16. Informant: Miss Jetta Bowers

Address: Reisterstown Md Route 2 Box127

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 24 1947 (month) (day) (year)

Cemetery or crematory: Wards Chapel Cemetery

Location: Holbrook Md

18. Funeral director: Wm Berryman & Sons

Address: Reisterstown Md

19. Sept. 23 19 47 (Date rec'd by registrar) Mary E. Line Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/22/47 at 3A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/1/43 19.. to 9/22/47 19.. and that I last saw her alive on 9/22/47 19..

Immediate cause of death	DURATION
Cerebral hemorrhage	3 days
Due to: hypertension	
Due to: arteriosclerosis	
Other conditions: Fractured hip - 1943	

(Include pregnancy within 3 months of death)

Major findings of operations: /

Date of op.: /

Autopsy results: /

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: / Date of: /

Where did injury occur? / (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): /

Means of injury: / Injured at work?

23. SIGNATURE: James G. Saffell M. D. or other

Address: Reisterstown Md Date signed: 9/23/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07728

93d

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 7 mos. 6 days

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 1 yr. 7 mos. 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: XXXXXX Pr. Geo. Co.

City or town: Forestville,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5496 First Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: BRADY, Samuel Bernard

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ida DeVaughn

6.(c) If alive, give age: 50? years

7. Birth date of deceased (mo., day, yr.): July 11, 1867

8. AGE: Years	Months	Days	If less than one day
80	1	23	....hrs. ....min.

9. Birthplace: Queen Anne, Pr. Geo. Co., Md.
(Town, county, and state)

10. Usual occupation: Court Crier

11. Industry or business: Court

FATHER
12. Name: Joseph Franklin Brady
13. Birthplace: Prince Geo. Co., Md/

MOTHER
14. Maiden name: Martha Ward
15. Birthplace: Prince Geo. Co., Md.

16. Informant: XXXXXXXXXXXXXXX Hospital record
Address: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX Catonsville- 28 Md.

17. Burial
(Burial, cremation, or removal. Which?) Date thereof 9-7-47 (month) (day) (year)

Cemetery or crematory: Forestville

Location: Forestville, Md.

16. Funeral director: Isidore Tuerk

Address: Catonsville, Md.

19. Filed 9-7-47 Samuel Thompson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 3 19 47 at 3:35 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 28, 1946 19.... to Sept. 3 19 47 and that I last saw him alive on Sept. 3 19 47

Immediate cause of death	DURATION
Cachexia	indefinite
Due to: Chronic hypertensive cardio-vascular disease	"
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ....Date of op.....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of.....

Where did injury occur? ....(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ....Injured at work?

23. SIGNATURE: Isidore Tuerk, M.D.

Address: Catonsville- 28, Maryland. M. D. or other

9-3-47 Date signed

VS A15 9-45-15M

PLEASE WRITE PLAINLY WITH INDELIBLE FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07726

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year, 11 months, 2 days

Hospital, Institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 1 year, 11 months, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: ?

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Brottman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	separated

6.(b) Name of husband or wife: Max Brottman

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1899

8. AGE: Years	Months	Days	If less than one day
48	?	?	hrs. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual occupation: None

11. Industry or business: Home

FATHER 12. Name: Joseph Poitner

FATHER 13. Birthplace: Russia

MOTHER 14. Maiden name: Beckie - ?

MOTHER 15. Birthplace: Russia

16. Informant: Hospital records

Address: Catonsville-28, Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof 9-9-47 (month) (day) (year)

Cemetery or crematory: Chek Sholom Cem

Location: O'Donnell St

18. Funeral director: Jack Lewis Inc

Address: 200 Eutaw Place

19. 9 11 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 6 1947, at 1:40 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 4 1945 to September 6 1947 and that I last saw her alive on September 6 1947

Immediate cause of death	DURATION
Carcinoma uterus with metastasis-	18 mos
Due to: Hypertensive cardiovascular-	
renal disease	years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. (M. D. or other)

Address: Catonsville-28, Md. Date signed: 9-8-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13- 07730

Reg. Diat. No. 42

P

1. PLACE OF DEATH:
County BALTIMORE COUNTY
City or town HALETHORPE, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County BALTIMORE
City or town HALETHORPE
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1260 June Road
(If rural, give LOCATION)
2.(a) If veteran, name war WORLD WAR#1

3.(a) FULL NAME: CLIVE THEODORE BROWN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	MARRIED

6.(b) Name of husband or wife: Ora E. Brown
6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): August 28, 1896

8. AGE: Years	Months	Days	If less than one day
51	0	21	....hrs. ....min.

8. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation:
11. Industry or business: Beth. Steel Co. Sp. Pt.

FATHER
12. Name: Joseph Brown
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Cecelia McDonald
15. Birthplace: Baltimore, Maryland

16. Informant: Mrs. Ora E. Brown - Widow
Address: 1260 June Rd. - 26

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/22/47 (month) (day) (year)
Cemetery or crematory: Baltimore National
Location: Baltimore, Maryland

18. Funeral director: HENRY SANDER & SONS, INC.
Address: NORTH AVE. & BROADWAY

19. 9/19/47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/18 19 47 at 10 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 47 to Sept. 18 19 47 and that I last saw h... alive on 9/18/47 19

Immediate cause of death	DURATION
Pulmonary Tuberculosis	6 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Benjamin Miller MD
M. D. or other
Address 1030 Wilkens ave Date signed 9/18/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

195d

07732 31

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
County Baltimore
City or town 3622 Oak Ave. Lochsum
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore-7
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3622 Oak Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Kathleen Marie Caldwell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1947

8. AGE:

Years	Months	Days	If less than one day
0	5	9	hrs. min.

9. Birthplace Baltimore City
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name Andrew V. Caldwell
13. Birthplace Baltimore City

MOTHER
14. Maiden name Isabelle Morrison
15. Birthplace Emmitsburg, Md.

16. Informant Mr. Andrew V. Caldwell
Address 3622 Oak Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/23/47 (month) (day) (year)
Cemetery or crematory Cathedral Com.
Location Baltimore City

18. Funeral director Co. Vernon Lemmon.
Address 4644 Park Heights. Balto. City.

19. 9/23 1947 A. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21 1947, at 8:40P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-21-'47 to 9-21-'47
and that I last saw her alive on not seen alive

Immediate cause of death	DURATION
Asphyxia	30 mins
Due to: Aspiration of vomits	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: NONE Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? NONE (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE D. D. Eagles Med. Exam. M. D. or other
Address Reisterstown, Md. Date signed 9-22-'47

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VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Prc 61

07733 (1) BP 1

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 Hrs.

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Ft. Howard, Md.

How long in hospital or institution? 14 Hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1417 E. Madison Street

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-2 ✓

3. (a) FULL NAME: HARRY CAMPBELL

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: //// Irene Campbell

6.(c) If alive, give age: 24 years

7. Birth date of deceased (mo., day, yr.): 3-22-21

8. AGE: Years	Months	Days	If less than one day
26	6	0	..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Pipe Fitter

11. Industry or business:

FATHER — 12. Name: Harry Campbell

13. Birthplace: Baltimore, Md.

MOTHER — 14. Maiden name: Viola Green

15. Birthplace: Baltimore, Md.

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Fort Howard, Md.

17. Burial (Burial, cremation, or removal, which?) Date thereof ..... (month) (day) (year)

Cemetery or crematory: Balt National

Location: Baltimore Md

18. Funeral director: Charles R. Lowe

Address: 802 Madison Ave.

19. 9/24 1947 (Date rec'd by registrar) H. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 22, 1947, at 8:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 21, 1947, to Sept. 22, 1947 and that I last saw him alive on Sept. 22, 1947

Immediate cause of death	DURATION
Coma	18 Hrs.
Due to: Diabetes Mellitus	Unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Substantiated Above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ..... Injured at work?

23. SIGNATURE: Robert M. Cullison M. D. or other

R. M. CULLISON, M.D. CLIN. DIR.

Address: V.A.H. FT. HOWARD, MD. Date signed: 9-22-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

07734

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville, Spring Grove, St H
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 months, 10 days.
Hospital, institution, or street address where death occurred:
Spring Grove St. Hosp.
How long in hospital or institution? 7 months, 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Jessup
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Charles Edwin CARTER

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widowed

6.(b) Name of husband or wife: Edith Carter
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 27th 1871

8. AGE: Years: 76 | Months: 7 | Days: 4 | If less than one day: hrs. min.

9. Birthplace: Illinois (Town, county, and state)

10. Usual occupation: Methodist Minister

11. Industry or business

FATHER
12. Name: Edwin R. Carter
13. Birthplace: Ohio

MOTHER
14. Maiden name: Mary Anne Cartmill
15. Birthplace: Ohio

16. Informant: Mrs. Lenora Davison
Address: Jessup, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 4, 1947. (month) (day) (year)
Cemetery or crematory: Meadowridge Cemetery
Location: Hwy-Balto Blvd Dorsey, Md.

18. Funeral director: Arthur Walters
Address: 505 Washington Blvd., Laurel, Md.

19. Sept 11 '47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 1st 1947, at 7 15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 21st 1947 to Sept 1st 1947 and that I last saw h. alive on Sept 1st 1947

Immediate cause of death	DURATION
Cardiac decompensation	24 hrs
Due to: hypertensive Cardio-vascular-reno disease	unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Gordon Lunde M.D. (M. D. or other)
Address: Spring Grove, Date signed: Sept. 1st

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information called for. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164a

07735

Reg. Diat. No. 30

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County: Balto.

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Harlem Lane

Hospital, institution, or street address where death occurred: Harlem Lodge Nursing Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Balto.

City or town: Catonsville (Balto Co.)

(If outside city or town limits, write RURAL and give nearest town)

Street No. Harlem Lane

(If rural, give LOCATION)

2.(a) If veteran, name war: W. W. #1

3.(a) FULL NAME: William B. Clagett

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, ~~married, widowed, or divorced~~
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 30th 1890

8. AGE: Years	Months	Days	If less than one day
56	10	20	hrs. min.

9. Birthplace: Upper Marlboro, Md (Town, county, and state)

10. Usual occupation: Lawyer

11. Industry or business: Self

FATHER — 12. Name: Wm B. Clagett

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: Katherine C. Duckett

MOTHER — 15. Birthplace: Md.

16. Informant: Charles Clagett

Address: Keyser Building, Balto. Md.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof SEPT. 23 1947 (month) (day) (year)

Cemetery or crematory: TRINITY

Location: UPPER MARLBORO, Md.

18. Funeral director: William Cook Inc.

Address: 1217 St. Paul st.

19. 9-22 19 47 (Date received by Registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 20 1947 at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hanging	
Due to: Strangulation	
Due to: suicide	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: suicide Date of: Sept. 20, 47

Where did injury occur? Catonsville (City or town) Balto. (County) md. (State)

Injured at home, farm, industry, public place (where?): public place

Means of injury: Hung himself from tree by rope Injured at work? no

23. SIGNATURE: G. W. Kieffer M. D. or other Exam. Balto Co. Dept Med

Address: 1010 Leadenhall Date signed: Sept 20 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

07736

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Armacost Nursing Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1531 E. North Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Emma Cole

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife: Capt. Charles M.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 31st 1871

8. AGE:

Years	Months	Days	If less than one day
76	1	18	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Unknown Weinreich

13. Birthplace: Germany

MOTHER

14. Maiden name: Unknown

15. Birthplace

16. Informant: Mr. James D. Cole

Address: 408 Dunkirk Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 23, 1947 (month) (day) (year)

Cemetery or crematory: Mt. Olivet Cemetery

Location: Baltimore, Md.

18. Funeral director: William J. Tickner & Sons

Address: North & Pennsylvania Aves.

19. Sept 22 19 47 (Date rec'd by registrar) C. N. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 19th 19 47 at 5:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5 19 46 to Sept 19 19 47 and that I last saw her alive on Sept 19 19 47

Immediate cause of death	DURATION
Hypertensive cardio-vascular disease	2 years
Due to	
Due to	
Other conditions: Pemphigus	2 mons.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John D. Bryant M.D. M. D. or other

Address: 1531 E North Ave Date signed: 21 Sept 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS (A15) 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940 07737

CERTIFICATE OF DEATH

Reg. Diat. No. 35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: BALTIMORE

City or town: RURAL - PARKTON

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 da.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: BALTO.

City or town: Hereford - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Number 6.0. - Jct. Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: George Cox

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: yeare

7. Birth date of deceased (mo., day, yr.): Not Known 1887

8. AGE: Yeare 60 — ? | Months | Days | If less than one day: hrs. min.

9. Birthplace: Balto. Co. Md. (Town, county, and state)

10. Ueual occupation: Seneral Laborer

11. Industry or business

FATHER 12. Name: Mack Cox

13. Birthplace: Balto. Co., Md.

MOTHER 14. Maiden name: Unknown

15. Birthplace

16. Informant: Mrs. John Eichler

Address: Timonium, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 17 1947 (month) (day) (year)

Cemetery or crematory: Hereford Baptist

Location: Hereford, Md.

18. Funeral director: Landon M. Brooks

Address: Sparks, Md

19. Sept. 17, 1947 (Date rec'd by registrar) Mr. Howard S. Markline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 14 19 47, at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19

aed that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary artery disease	
Due to	
Due to	
Other conditions	

(Includo pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A. M. France M. D. or other

Address: Parkton, Md. Date signed: 9/14/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a 07738 38

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Stoneleigh
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months

Hospital, institution, or street address where death occurred:
Armacost Nursing Home, 812 Register Ave.

How long in hospital or institution? 6 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Linthicum Heights
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 331 E. Maple Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Sarah Cora Benson Cromwell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

8.(b) Name of husband or wife: Harry H. Cromwell

8.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 12, 1876

8. AGE:	Years	Months	Days	If less than one day
	71	6	28	..... hrs. ..... min.

9. Birthplace: Anne Arundel County (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER
12. Name: James R. Benson
13. Birthplace: Anne Arundel County, Md.

MOTHER
14. Maiden name: Fannie Hodges
15. Birthplace: Anne Arundel County, Md.

16. Informant: Mr. Herbert Cromwell
Address: 108 S. Camp Mead Road, Linthicum Hts.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9/11/47 (month) (day) (year)

Cemetery: Cedar Hill

Location: Annapolis Road, Brooklyn, Md.

18. Funeral director: John O. Mitchell & Sons, Inc.

Address: 1900 Eutaw Place, Baltimore, Md.

19. 9/11 (Date rec'd by registrar) 19 47 A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 9 19 47 at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5 19 47 to Sept 8 19 47

and that I last saw her alive on Sept 8 19 47

Immediate cause of death	DURATION
Apoplexy	10 hrs.
Due to: Arterio-Sclerosis & Hypertension	Long
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Paul H. Kelly M.D.
M. D. or other

Address: Towson, Md. Date signed: 9/10/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07739 Reg. Diat. No. 33

1. PLACE OF DEATH:
County: Baltimore
City or town: Reisterstown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Int. Pleasant Sanatorium
Stay in hospital or inst. (yrs., or mos., or days): 24 days.
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 3506 Park Heights Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Benjamin Dachslager

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	white	Widowed

B (b) Name of husband or wife: Late Rachael
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 12, 1878

8. AGE:

Years	Months	Days	If less than one day
69	5	26	hrs. min.

9. Birthplace: Austria (Town, county, and state)
10. Usual occupation: Shoe Repairer
11. Industry or business

FATHER
12. Name: Abraham Dachslager.
13. Birthplace: Austria

MOTHER
14. Maiden name: Lea Fleisher
15. Birthplace: Austria.

16. Informant: Freda Dachslager (Daughter)
Address: 3506 Park Heights Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 8 1947 (month) (day) (year)
Cemetery or crematory: Shaarei Zion Cemety
Location: Hamilton ave. Roedale

18. Funeral director: Sol Levinson & Bros.
Address: 1624-26 W North ave

19. 9/8 19 47 Sa. Bedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 7, 1947 at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 13, 1947, to Sept. 7, 1947, and that I last saw him alive on Sept 7, 1947

Immediate cause of death: Myocardial Failure — DURATION: 5 days
Chest x ray showed small shadow thought to be primary bronchogenic Carcinoma. Also marked enlargement of prostate
Due to Carcinoma. Also marked enlargement of prostate
Conditions of larynx. Since death the autopsy showed pulmonary tuberculosis
Due to and tuberculous laryngitis to be cause of death. 4 mos.
Other conditions: Syphilis 8 yrs.

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Albert F. Shrier M.D.
M. D. or other
Address: Reisterstown, Md. Date signed: 9/7/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a 07740

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Westowne
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 Mos.

Hospital, institution, or street address where death occurred:
Hood Nursing Home
5501 Edmondson Ave.,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3010 Grayson St.,
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME: Catherine (Katie) Derenberger

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: xx James J. Derenberger

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 23, 1871

8. AGE: Years	Months	Days	If less than one day
75	11	9	..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: At Home

11. Industry or business

FATHER
12. Name: Edward J. Griffin
13. Birthplace: Ireland

MOTHER
14. Maiden name: Mary McEnaney
15. Birthplace: Ireland

16. Informant: Mr. J. Edward Derenberger (Son)
Address: 2314 Rosedale St.,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-4-1947 (month) (day) (year)

Cemetery or crematory: Cathedral

Location: Baltimore, Md.

18. Funeral director: D. Howard Strong

Address: 3207 W. North Ave.

19. Sept 3 1947 (Date rec'd by registrar) A. W. Hebeler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 1, 1947 at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1947 to Sept 1 1947 and that I last saw h... alive on Sept 1 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jerome Towers M. D. or other

Address: Date signed 9-7

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

07741

CERTIFICATE OF DEATH

Reg. Dist. No. 24 30

1. PLACE OF DEATH

County Balto Co

City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 weeks

Hospital, institution, or street address where death occurred:
16 Frederick ave

How long in hospital or institution? 12 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Balto Co

City or town Catonsville Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6 Osborne ave
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Georgiana Dow

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 19 1864

8. AGE: Years	Months	Days	If less than one day
80			..... hrs. ..... min.

9. Birthplace N Y (Town, county, and state)

10. Usual occupation Minister

11. Industry or business Retired

FATHER
12. Name Josiah M Dow
13. Birthplace N Y

MOTHER
14. Maiden name Kate W Downing
15. Birthplace

16. Informant Mary L McKibben
Address 6 Osborne ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 20/47 (month) (day) (year)

Cemetery or crematory Columbia Gardens

Location Arlington Va

18. Funeral director Edward Mac Nabb

Address Catonsville Md

19. ..... 19 ..... Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 Sept 19 47, at 6.15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 31 19 47, to 17 Sept 19 47

and that I last saw h. l. m. alive on Sept 17 19 47

	DURATION
Immediate cause of death Myocardial dilatation and failure	3 DAYS
Due to Arteriosclerosis Generalized	YEARS
Due to	
Other conditions SCIRRHOUS CA - LFT BREAST - MASTECTOMY Aug 46 (Include pregnancy within 3 months of death)	?

Major findings of operation FIBROUS ADHESION - MID DESCENDING COLON Date of op. 30 July 47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Stephen Lee Maguess MD
M. D. or other

Address Catonsville 28, Md Date signed 19 Sept 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

COPY SENT TO ~~LOCAL~~ REGISTRAR No. C&O. DATE 9/24/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

07742

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:
County Balto.
City or town Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Charles Emory Eckenrode

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Emma M.Eckenrode
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 30,1868

8. AGE: Years	Months	Days	If less than one day
79	5	26	hrs. min.

9. Birthplace Hanover Pa.
(Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name Joseph Eckenrode
13. Birthplace Penna.

MOTHER
14. Maiden name Josephine Atlhoff
15. Birthplace Penna.

16. Informant Emma M.Eckenrode
Address Main St.Reisterstown,Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept.27,1947 (month) (day) (year)
Cemetery or crematory Druid ridge
Location Balto.Co.

18. Funeral director J.F.Eline & Sons
Address Reisterstown,Md.

19. Sept.26-19 47 (Date rec'd by registrar) Mary B.Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25 1947, at 8:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/1/35, to 9/25/47 and that I last saw h[illegible] alive on 9/24/47

	DURATION
Immediate cause of death Coronary Thrombosis	few minutes
Due to hypotension	
Due to Myocardial Chronic	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James G. Lafell M. D. or other
Address Reisterstown Md. Date signed 9/25/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

07743

Reg. Dist. No. 27

1. PLACE OF DEATH:
County 1322 Linden ave. Halethorpe, Md.
City or town Balto. Co. Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
SARAH E. ELLIOTT

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6.(b) Name of husband or wife EDWARD J. ELLIOTT
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 18-1875

8. AGE: Years	Months	Days	If less than one day
72	5	21	hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Anthony Griffin
13. Birthplace umknown

MOTHER
14. Maiden name Bridget Kavanaugh
15. Birthplace Ireland

16. Informant Mrs. Howard Murphy (Niece)
Address 1118 Washington Blvd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-26-47 (month) (day) (year)
Cemetery or crematory Lprraine Cem.
Location Woodlawn, Md.
18. Funeral director John J Kenny
Address 5655 Osborne Rd, Halethorpe Md

19. Sept 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 19 47, at 1:20 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 13 19 47, to Sept 21 19 47
and that I last saw h.. alive on Sept 21 19 47

Immediate cause of death Cardiac failure — DURATION
Due to Chronic Myocarditis
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Albert Scarpetta M. D. or other
Address 1729 W Lombard St Date signed 9/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07744

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1623 W. Gay Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3. (a) FULL NAME: HARRY FLANIGAN

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 5-26-1893

8. AGE: Years	Months	Days	If less than one day
54	3	21	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER
12. Name: Robert Flanigan
13. Birthplace: New York

MOTHER
14. Maiden name: Louise Grebe
15. Birthplace: Baltimore, Md.

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-22-47 (month) (day) (year)

Cemetery or crematory: Loudon Park Cemetery

Location: Frederick Rd. Balto. Md.

18. Funeral director: Albert L. Hilt

Address: 1606 N. Chester Street

19. 9/19 19 47 A. W. Blanck Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 17, 1947 at 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 17, 1947 to September 17 1947 and that I last saw him alive on September 17, 1947

Immediate cause of death	DURATION
Peritonitis with paralytic ileus	1 day
Due to: Perforation of sigmoid	1 day
Due to: Subacute Colitis	3 Wks.
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.:

Autopsy results: Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. D. Evans Jr. M.D. Asst. Med. Exam. M. D. or other

Address: Baltimore, Md. Date signed: 9/18/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

07745 C

CERTIFICATE OF DEATH

Reg. Dist. No. 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

VS A15

1. PLACE OF DEATH

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Mt. Hope

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Balto. Ward No.:

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 161 Lexington St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Ella M. Ford

3. (b) Social Security Number:

4. Sex: F

5. Color or race: W

6. (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Charles E.

(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1/7/1882

8. AGE: Years: 65 Months: 7 Days: 28 If less than one day: hrs. min.

9. Birthplace: Balto. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER 12. Name: Geo. A. Myers

13. Birthplace: Md.

MOTHER 14. Maiden name: Anna R. Simonette

15. Birthplace: Md.

16. Informant: Family

Address: 161 Lexington St. B.

17. (Burial, cremation, or removal. Which?) Date thereof 9-9-47 (month) (day), (year)

Cemetery or crematory: Cedar Hill

Location: Beaufort Sta.

18. Funeral director: J. F. McCully

Address: 130 E. Fort Ave.

19. 9/8 19 47 (Date rec'd by registrar) A. M. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 5 19 47, at 10P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3 19 47, to Sept 5 19 47, and that I last saw her alive on Sept 5 19 47

	DURATION
Immediate cause of death: Acute Edema of Lungs.	24 hrs.
Due to: Cerebral Hemorrhage.	6 mos.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: none

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R. E. K. Campbell M. D. or other

Address: 164 Hanover St. Date signed: 9/8/47

07746

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830

Registered No. 43

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4508 Kenwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore 6 (If outside city or town limits, write RURAL and give town)
(d) Street No. 4508 Kenwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Gebhardt

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Christopher Gebhardt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8, 1874

8. AGE: Years 73 | Months 2 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore County, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own home

FATHER
12. Name Charles Neubauer
13. Birthplace Germany

MOTHER
14. Maiden Name Sophie Bodenschatz
15. Birthplace Germany

16 (a) Informant George Gebhardt
(b) Address 4508 Kenwood Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 9/8/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Rd.

19 (a) Sept 5 1947 (Date rec'd by registrar) (b) Mary E. Reynolds Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1947, at 12:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1947, to Sept 4 1947, and that I last saw her alive on Sept 3 1947.

Immediate cause of death: Cerebral Hemorrhage — Duration: 40 hrs.
Due to: Hypertension — Duration: Many years.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Max R. English M. D.
Address 5713 Belair Rd. Date signed 9-4-47
Balt 6, Md.

VS 150

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07747 f.

Reg. Dist. No. .....

1. PLACE OF DEATH

County: Baltimore

City or town: Arbutus

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Howard

City or town: Arbutus

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1320 Elm Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Irene Geyer

3. (b) Social Security Number 217-09-7961

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married -

6.(b) Name of husband or wife: George Geyer -

6.(c) If alive, give age: 27 years

7. Birth date of deceased (mo., day, yr.): Oct 12 - 1919

8. AGE: Years	Months	Days	If less than one day
27	11		..... hrs. ..... min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: self -

FATHER — 12. Name: Chas F. Brown

FATHER — 13. Birthplace: Baltimore Md.

MOTHER — 14. Maiden name: Florence Purpur

MOTHER — 15. Birthplace: Baltimore Md

16. Informant: Margaret Baker.

Address: 1306 Elm Rd H. Co

17. Burial - (Burial, cremation, or removal. Which?) Date thereof: Sept 16-47 (month) (day) (year)

Cemetery or crematory: Meadows Ridge Cem -

Location

18. Funeral director: Chas F Powell

Address: 21 Edmondson Ave.

19. Sept 15 1947 (Date rec'd by registrar) C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 12 - 1947 at 8:15 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 5 19 47 to Sept. 12 19 47 and that I last saw h[illegible] alive on Sept 12 19 47

Immediate cause of death	DURATION
Broncho-Pneumonia	
Due to Carcinoma of Lung	
Due to Carcinoma of Liver	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: M. E. Spitzmueller M.D. or other

Address: Catonsville Md Date signed 9/13/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr Spitznagle
Lansdowne md. –

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

33a

Reg. Dist. No. 07748 6/1

1. PLACE OF DEATH:
County Baltimore
City or town 813 Wise ave., Dundalk 22
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town 81 B Wise ave
(If outside city or town limits, write RURAL and give nearest town)
Street No. Dundalk 22 ms
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Louise Henrietta Glesmer

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife Julius Glesmer
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 24, 1873

8. AGE: Years	Months	Days	If less than one day
74	4	10	..... hrs. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name ? Wetzell
13. Birthplace Maryland

MOTHER
14. Maiden name Elizabeth Capeller
15. Birthplace Maryland

16. Informant Mr. August Glesmer
Address 813 Wise Avenue - 22

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/6/47 (month) (day) (year)
Cemetery or crematory Mount Carmel Cemetery
Location Baltimore, Maryland
18. Funeral director HENRY SANDER & SONS, INC.
Address NORTH AVE. & BROADWAY

19. 9-5 47 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 4th, 47, at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1st, 1947 to September 4th 1947 and that I last saw h.. alive on September 3rd, 1947

Immediate cause of death	DURATION
Lobar pneumonia	2 wks
Due to Influenza	2 wks
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE J. H. Thomas M.D., M. D. or other
Address Dundalk Sta 22 Date signed 9/4/47

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a 07749 38

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Presbyterian Home

How long in hospital or institution? 24 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. (Pa.) County: Baltimore

City or town: (Towson (Washington)
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Presbyterian Home
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mary M. Godfrey

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Joseph William Godfrey

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 12, 1865

8. AGE:

Years	Months	Days	If less than one day
82	5	15	hrs. min.

9. Birthplace: Washington, Pa.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Robert L. Miller
13. Birthplace: Pa.

MOTHER
14. Maiden name: Charlotte Lindsay
15. Birthplace: Pa.

16. Informant: deceased, above
Address: Presbyterian Home, Towson

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/30/47 (month) (day) (year)

Cemetery or crematory: Washington

Location: Washington, Pa.

18. Funeral director: John A. Mitchell & Sons, Inc.

Address: 1900 Eutaw Place, Baltimore, Md.

19. 9-29 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 26 19 47 at 1110 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary Occlusion	sudden
Due to: Was found dead in	
Due to: bedroom morning of	
Sept 27, 47.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John A. Green M. D.
Deputy medical Examiner
M. D. or other

Address: Towson Md. Date signed 9/27/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

BC 47C

07750

CERTIFICATE OF DEATH

Reg. Dist. No. 4X

1. PLACE OF DEATH:
County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Md.
How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2227 Mura St.,
(If rural, give LOCATION)
2.(a) If veteran, name war WW-I ✓

3.(a) FULL NAME: CHRISTOPHER GOETZ

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Goetz
6.(c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) 9-29-95

8. AGE: Years	Months	Days	If less than one day
51	11	22	..... hrs. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual occupation Time Clerk
11. Industry or business

FATHER
12. Name John Goetz
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden name Barbara Bowdie
15. Birthplace Baltimore, Md.

16. Informant Clinical Records, Vets. Adm. Hosp
Address Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-24-47 (month) (day) (year)
Cemetery or crematory Baltimore National Cemetery
Location Baltimore, Md.
18. Funeral director Albert Hiltz Albert Hiltz
Address 1606 N. Chester St. Balto., Md.

19. 9/22 1947 (Date filed by registrar) H. W. Redrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 20, 1947, 3:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 18, 1947, to Sept. 20, 1947 and that I last saw him alive on September 20, 1947

Immediate cause of death	DURATION
Bronchiogenic carcinoma of left Lung Metastatic to Mediastinum right pleura Parietal Pericardium Para Aortic Nodes, and Adrenals	unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Robert J. Scott
ROBERT J. SCOTT, MD. M. D. or other
Address V.A.H. Fort Howard, Md. Date signed 9/20/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

07751

Reg. Diat. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Catonsville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2720 Frederick Road.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Catherine A Hahn

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife: Edward Hahn
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 24, 1867

8. AGE: Years	Months	Days	If less than one day
79	9	12	..... hrs. ..... min.

9. Birthplace: Ellicott City Md. (Town, county, and state)
10. Usual occupation: at home
11. Industry or business
FATHER 12. Name: Peter Lynch.
13. Birthplace: Md.
MOTHER 14. Maiden name: Anna M. Lawman
15. Birthplace: Germany.
18. Informant: Mrs Kenneth Cook.
Address: Catonsville Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-9-47 (month) (day) (year)
Cemetery or crematory: Loudon Park.
Location: Baltimore Md.
18. Funeral director: H.C. Nigenbottom
Address: Ellicott City Md
19. 9/8 1947 (Date rec'd by registrar) J. Carroll Cunningham Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 6 1947 at 6P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1 1947 to Sept 6 1947
and that I last saw h.. alive on Sept 6 1947

Immediate cause of death	DURATION
Arteriosclerotic heart disease	7
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Jas B Kerbaugh M.D.
M. D. or other
Address: Ellicott City Md Date signed 9/5/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93b 07752

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:
County: Balto.
City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war.

3.(a) FULL NAME: Harry Benton Hann

3.(b) Social Security Number: 217-12-1609

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Vera A. Hann
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 23, 1922

8. AGE: Years	Months	Days	If less than one day
25	8	1	..... hrs. ..... min.

9. Birthplace: Carroll Co.
(Town, county, and state)
10. Usual occupation: Gas Station Attendant
11. Industry or business
FATHER 12. Name: Harry F. Hann
13. Birthplace: Carroll Co.
MOTHER 14. Maiden name: Beulah M. Reed
15. Birthplace: Carroll Co.
16. Informant: Vera A. Hann
Address: Reisterstown, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 26, 1947 (month) (day) (year)
Cemetery or crematory: All-Saints
Location: Reisterstown, Md.
18. Funeral director: J. F. Eline & Sons
Address: Reisterstown, Md.
19. Sept-26-1947 (Date rec'd by registrar) Mary B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 24 1947, at 11 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/1/40 to 9/24/47
and that I last saw h/ alive on 9/24/47
Immediate cause of death: Myocarditis — DURATION: Few hours
Due to: Bronchial asthma severe
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James L. Saffell M. D. or other
Address: Reisterstown Md. Date signed 9-25-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07753

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Baltimore

City or town Stevenson, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? One Month

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Stevenson
(If outside city or town limits, write RURAL and give nearest town)

Street No. Valley Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sister Agnes Julienne
nee Alice Harrington

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	S

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 8, 1916

8. AGE: Years	Months	Days	If less than one day
30	11	8	..... hrs. ..... min.

9. Birthplace South Boston, Massachusetts
(Town, county, and state)

10. Usual occupation Teacher

11. Industry or business

FATHER 12. Name John Harrington

13. Birthplace Ireland

MOTHER 14. Maiden name Delia Dailey

15. Birthplace Ireland

16. Informant Sister Pratia, Provincial

Address Valley Road, Stevenson, Md.

17. Burial
(Burial, cremation, or removal? Which?) Date thereof ..... (month) (day) (year)

Cemetery or crematory Convent Cemetery

Location Catholic Dept.

18. Funeral director Guy A. Talley

Address Catonsville Md

19. ..... 19..... Monrovia Md
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1947 at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 1947 to Sept 16 1947 and that I last saw ..... alive on Sept 16 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	6 mo.
Due to Tuberculosis of Bowels	3 mo.
Due to " of Larynx	6 mo.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Sister M. Julienne, M.D. or other

Address Stella 103 W 39th St Date signed .....

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07754

94a

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Baltimore
City or town Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
Street No. 714 E. St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Albert W. Hastings

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Julia
6.(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) January 29, 1880

8. AGE: Years 67 Months Days If less than one day ..... hrs. ..... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation Machinist

11. Industry or business Beth Steel Co.

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden name "
15. Birthplace "

16. Informant Mrs Julia Hastings
Address 714 E. St. Sparrows Point

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/16/47 (month) (day) (year)
Cemetery or crematory Moreland Memorial
Location Taylor Ave

18. Funeral director John F. Denny Inc. 46
Address 615 Eight St.

19. 9-6 19 47 A.W. Hedrich Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 4th 1947 at 9:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10, 1947 19 to Sept 3 1947 and that I last saw h. alive on Sept 3, 1947 19

Immediate cause of death	DURATION
Acute Coronary Occlusion	12 hrs.
Due to: Coronary Artery disease	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address 520 D St. Sparrows Point Date signed 9-4-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

33a 07755

CERTIFICATE OF DEATH

Reg. Dist. No. 4W

1. PLACE OF DEATH:
County Baltimore
City or town Mayo's Lane #22 Cottage Ave Dundalk Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town R.F.D. Lansdale Pa. Box 22
(If outside city or town limits, write RURAL and give nearest town)
Street No. #22 Cottage Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Henderson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	col	W

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 82 | Months | Days | If less than one day hrs. mio.

9. Birthplace Calvert Co. Md (Town, county, and state)

10. Usual occupation House Work

11. Industry or business

FATHER 12. Name Benjamin Yates
13. Birthplace Calvert Co. Md

MOTHER 14. Maiden name Mattie Yates
15. Birthplace Calvert Co. Md

16. Informant Dock Rawlings
Address 22 Cottage ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 13. 1947 (month) (day) (year)
Cemetery or crematory Mt Calvery Cem
Location Brooklyn Md

18. Funeral director Elroy O. Wilson
Address 1000 Brantley ave

19. 9/11 (Date rec'd by registrar) 19 47 H. H. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10th 1947 at 1.20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 2nd 19 47, to Sept 10th 19 47 and that I last saw h.... alive on Sept 10th 1947

Immediate cause of death	DURATION
Bronchopneumonia	10 days
Due to Arteriosclerosis	15 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. H. Thomas M.D. M. D. or other
Address Dunkirk Md. Date signed 9/10/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07756

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: 636 North Bend Rd

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 636 North Bend Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William M. Henry

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Agnes S. Henry

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 1, 1873

8. AGE: Years	Months	Days	If less than one day
74	5	24	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER 12. Name: Barthold Henry

13. Birthplace: Germany

MOTHER 14. Maiden name: Sophia

15. Birthplace: Germany

16. Informant: Leo J. Henry

Address: 6400 Oakeley Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-27-47 (month) (day) (year)

Cemetery or crematory: Cathedral

Location: Baltimore

18. Funeral director: George A Farley

Address: Fulton Ave & Fayette St.

19. (Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 24 1947, at 1305 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 18 1947, to Sept 24 1947

and that I last saw him alive on September 23 1947

Immediate cause of death	DURATION
Coronary Thrombosis	15 minutes
Due to: Generalized arterial sclerosis	
Due to: Prostatic hypertrophy with urinary retention and	
Other conditions: chronic cystitis	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. Michel M.D. M. D. or other

Address: 590 E Edmondson Ave Date signed: Sept 25 '47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

478 07757

CERTIFICATE OF DEATH

Reg. Diat. No. 41

1. PLACE OF DEATH:

County: Baltimore

City or town: Dundalk

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Dundalk

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1401 Espew ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Julius F. Hodges

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	M.

6.(b) Name of husband or wife: Elizabeth M. Hodges

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 20, 1882

8. AGE: Years	Months	Days	If less than one day
65	4	21	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Warehouse Foreman

11. Industry or business: National Distilling

FATHER 12. Name: George Hodges

13. Birthplace: Md.

MOTHER 14. Maiden name: Mary Engle

15. Birthplace: Md.

16. Informant: Mrs. Elizabeth M. Hodges

Address: 1401 Espew ave, Dundalk

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 12, 1947 (month) (day) (year)

Cemetery or crematory: Sacred Heart

Location: German Hill Road

18. Funeral director: Roland L. Fisher

Address: 2112 Dundalk Ave.

19. 9/12/47 (Date rec'd by registrar) W. M. Learned Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 10 1947, at 7:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947 to Sept 10, 1947 and that I last saw him alive on Sept 9, 1947

Immediate cause of death	DURATION
Tumor of mediastinum	
probably carcinoma.	3 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: David H. Andrew M.D. M. D. or other

Address: Dundalk Md. Date signed Sept 10, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a 07758

CERTIFICATE OF DEATH

Reg. Dist. No. 37

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Balto.
City or town Lutherville Md-
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: York Rd-
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto.
City or town Lutherville Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. York Rd-
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John Solomon Hodges.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-	Widowed

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 10 1867.

8. AGE:

Years	Months	Days	If less than one day
80		2	hrs. min.

9. Birthplace Balto. Md-
(Town, county, and state)
10. Usual occupation Laborer.
11. Industry or business Gen.
FATHER 12. Name John S. Hodges-
13. Birthplace Balto. Md-
MOTHER 14. Maiden name Mary Cooper.
15. Birthplace Balto Md-
16. Informant Mary Dyer.
Address Lutherville Md
17. Burial Date thereof 9-14-47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Poplar
Location Cockeysville, Md.
18. Funeral director John Burns' Sons
Address Towson, Md.
19. 9-12- 47 Wilmer C. Ensor
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1947, at 9 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 15 1942, to 9/12 1947
and that I last saw h- alive on 9/11 1947.

Immediate cause of death	Myocarditis	5 yrs
Due to	Chronic Syphilitis	
Due to	Arterio sclerosis -	
Other conditions		

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wilmer C. Ensor M.D
M. D. or other
Address Cockeysville Md- Date signed 9/12/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92 C

07751

8

CERTIFICATE OF DEATH

Reg. Dist. No. 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A-5

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 46 Winters Land

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Baltimore

City or town: Catonsville Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 46 Winters Lane

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME Louis Frisby Hodges

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

8 (b) Name of husband or wife: Elizabeth Hodges

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 10, 1885

8. AGE: Years	Months	Days	If less than one day
62	3	1	hrs. min.

9. Birthplace: Still Pond, Md. (Town, county, and state)

10. Usual occupation: Minister

11. Industry or business:

FATHER — 12. Name: Unknown

13. Birthplace: "

MOTHER — 14. Maiden name: Unknown

15. Birthplace: "

16. Informant: Mrs. Elizabeth Hodges

Address: 46 Winters Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-15-47 (month) (day) (year)

Cemetery or crematory:

Location: Still Pond, Maryland

18. Funeral director: Mrs. Frances A. Hemsley

Address: 578 W. Biddle St.

19. Sept 15 1947 (Date rec'd by registrar) A. W. Hedgecock Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 11th 1947, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-2-46 19 to 9-11-47 19, and that I last saw h alive on 9-11-47 19

	DURATION
Immediate cause of death: Mitral Insufficiency	?
Due to: Arterio-sclerosis	?
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: —

Of autopsy: —

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. F. Maloney M.D. M. D. or other

Address: Catonsville, Md. Date signed: 9-11-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a 07760

CERTIFICATE OF DEATH

Reg. Dist. No. 33

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS A15

1. PLACE OF DEATH:
County: Balto
City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Silver Cross Nursing Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Grace Darling Holmes

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Nov 28th 1866

8. AGE: Years	Months	Days	If less than one day
80	9	26	____ hrs. ____ min.

9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER 12. Name: Samuel Holmes
13. Birthplace: England
MOTHER 14. Maiden name: Mary E. Ogle
15. Birthplace: Md
16. Informant: Mrs. Allen Burns (Nieca)
Address: 4305 Marble Hill Rd. Northway apt 2
17. Burial (Burial, cremation, or removal). Which? Date thereof 9/26/47 (month) (day) (year)
Cemetery or crematory: Mt Olivet
Location: Baltimore Md
19. Funeral director: Milton Cockey
Address: 1214 N Carey St
19. 9-25 19 47 (Date recd by registrar) J. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 24 19 47 at 2:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-24-'47 19 to 9-24-'47 19
and that I last saw her alive on not seen alive 19

Immediate cause of death	DURATION
Cerebral Hemorrhage	20 mins
Due to: Cerebral Thrombosis	10 yrs.
Due to:	
Other conditions: Catalepsy and Epilepsy (Include pregnancy within 3 months of death)	70 yrs

Major findings of operations: NONE Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? NONE (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Dr. D. D. Caples Med. Exam. M. D. or other
Address: Reisterstown, Md Date signed 9-24-'47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

07761

CERTIFICATE OF DEATH

Reg. Diat. No. 42

1. PLACE OF DEATH:
County Baltimore
City or town Arbutus
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4404 Leeds Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Frederick W. Holtgreve

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widowed

6.(b) Name of husband or wife late Frieda Gosker
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 2, 1866

8. AGE: Years	Months	Days	If less than one day
81	3	18	..... hrs. ..... min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual occupation Retired
11. Industry or business

FATHER	12. Name	Frederick Holtgreve
	13. Birthplace	Germany
MOTHER	14. Maiden name	Anna —
	15. Birthplace	Germany

16. Informant Harry Lamborghi
Address 1448 Patapsco Ave
17. Burial Date thereof 9.23.47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Loudon Park
Location 3801 Frederick Rd
18. Funeral director Harry H. Witzke
Address 4101 Edmondson Ave
19. 9/23 19 47 A.W. Hebert Jr. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 19 47 at 1:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 13 19 47 to Sept 21 19 47 and that I last saw h[illegible] alive on Sept 21 19 47

Immediate cause of death	Cardiac Failure	
Due to	Chronic Myocarditis	
Due to		
Other conditions	Chronic Cholecystitis	

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Albert Scagnetti M. D. or other
Address 1729 W. Lombard St Date signed 9/22/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a 07762 Reg. Dist. No. 4K

8

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard:
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Two days

Hospital, institution, or street address where death occurred:
VAH Fort Howard, Maryland

How long in hospital or institution? Two days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Balto.

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2609 Taylor Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: W.W. I - Retired

3. (a) FULL NAME: JOHN M. HOUSE

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Virginia C. House (nee Ayres)

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 9/28/79

8. AGE: Years	Months	Days	If less than one day
67	11	13	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER
12. Name: Michael House
13. Birthplace: Germany

MOTHER
14. Maiden name: Margaret Ackerman
15. Birthplace: Germany

16. Informant: Clinical Records
Address: VA Hospital Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9/15/47 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Maryland

18. Funeral director: William J. Tickner

Address: Baltimore, Maryland

19. 9/12 1947 (Date rec'd by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 11 19 47 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 9 1947 to September 11 1947 and that I last saw him alive on September 11 1947

Immediate cause of death	DURATION
HEMORRHAGE, CEREBRAL	3 days
Due to Hypertension, Arterial	Unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert M. Cullison
ROBERT M. CULLISON, M.D. (M. D. or other)

Address: VAH Fort Howard, Md. Date signed: 9/11/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07763

938

Reg. Dist. No. 32

1. PLACE OF DEATH:

County: Baltimore

City or town: Pikesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? four months

Hospital, institution, or street address where death occurred:

How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Sudbrook Park
(If outside city or town limits, write RURAL and give nearest town)

Street No. 710 Cliveden Road
(If rural, give LOCATION)

2.(a) If veteran, name war: --

3.(a) FULL NAME: Della Aretta Howe

3.(b) Social Security Number: --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife: Edward Martin Howe

deceased 6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): December 29, 1871

8. AGE: Years	Months	Days	If less than one day
~~76~~ 75	8	~~16~~ 17	____ hrs. ____ min.

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER
12. Name: John Greninger
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Mary Jane Gramly
15. Birthplace: Pennsylvania

16. Informant: Mrs. William Zimmerman

Address: Sudbrook Park, Balto. County, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: September 18, 1947 (month) (day) (year)

Cemetery or crematory: Maitland Church Cemetery

Location: Lewistown, Pennsylvania

18. Funeral director: Frank H. Newell

Address: Pikesville, Maryland

19. 9-18-47 (Date rec'd by registrar) E E Mitchell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 15 1947 at 10:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 30 1947, to September 15 1947 and that I last saw h...or...alive on September 14 1947

Immediate cause of death	DURATION
Chronic Myocarditis	?
Due to: Arterial Hypertension	?
Due to: Arterio Sclerosis	?
Other conditions: Cerebral Hemorrhage	45 days

(Include pregnancy within 3 months of death)

Major findings of operation: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: E E Mitchell M.D.

M. D. or other

Address: Pikesville, Md. Date signed: 9-18-47

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07764 Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 Days

Hospital, institution, or street address where death occurred: Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 45 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 420 Myrtle Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-2

3.(a) FULL NAME: JAMES JACKSON

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Divorced.

6.(b) Name of husband or wife: Divorced.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1-11-03

8. AGE: Years	Months	Days	If less than one day
44	8	11	..... hrs. ..... min.

9. Birthplace: Darlington, S. C.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Charles Jackson
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Emma Pierce
15. Birthplace: South Carolina

16. Informant: Clinical Records, Vet. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory: Body shipped to Darlington, S.C for burial

Location:

18. Funeral director: Charles R. Law
Address: 802 Madison Ave., Balto., Md.

19. 9 24 1947 (Date rec'd by registrar) J. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 22, 1947 at 1:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 8, 1947 to Sept. 22, 1947 and that I last saw him alive on Sept. 22, 1947

Immediate cause of death	DURATION
Tuberculosis, pulmonary, bilateral with cavitation	44 days plus
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert M. Cullison M. D. or other

R. M. CULLISON, M.D. CLIN. DIR.

Address: V.A.H., FORT HOWARD, MD. Date signed: 9-22-47

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 55 — 07765

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 166 days

Hospital, institution, or street address where death occurred:

Vet's Adm. Hosp. Fort Howard, Md.

How long in hospital or institution? 166 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 225 S. Green Street (If rural, give LOCATION)

2.(a) If veteran, name war: WW II

3.(a) FULL NAME: HARRY JENIFER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: Widowed

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 8-22-1902

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
45	0	14		

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: Harry Jenifer

13. Birthplace: Baltimore, Maryland

MOTHER — 14. Maiden name: Lillian Owens

15. Birthplace: Baltimore, Maryland

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9-11-47 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Maryland

18. Funeral director: Charles R. Law

Address: 802 Madison Ave., Balto., Md.

19. 9/9 (Date received by registrar) 1947 A.D. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 6, 1947, at 8:06 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 24, 1947, to September 6, 1947 and that I last saw him alive on September 6, 1947

Immediate cause of death	DURATION
Tuberculosis, pulmonary, chronic, cavitation	7 Mos. plus.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results: Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison M. D. or other

R. M. CULLISON, M.D. CLIN. DIR.

Address: V.A.H. FORT HOWARD, MD. Date signed: 9-8-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07766 C

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

VAH Fort Howard, Maryland

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 805 N. Parish St.

(If rural, give LOCATION)

2.(a) If veteran, name war: W. W. I

3.(a) FULL NAME

ROBERT W. JOHNSON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married - Sep.

6.(b) Name of husband or wife: Queen Johnson

6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): 7-4-88

8. AGE: Years	Months	Days	If less than one day
59	2	12	....hrs. ....min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: Albert Johnson

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Mary Brown

MOTHER — 15. Birthplace: Unknown

16. Informant: Clinical Records, Vets.Adm. Hosp.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/20/47 (month) (day) (year)

Cemetery or crematory: Balto. National Cem.

Location: Frederick Ave. Balto. Md.

18. Funeral director: Metropolitan Funeral Home Inc.

Address: 927 N. Mount St.

19. 9/19/47 (Date rec'd by registrar) 19.... A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 16 19 47 at 8:18 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 15 19 47 to September 16 19 47 and that I last saw h.im alive on September 16 19 47

Immediate cause of death	DURATION
Tuberculosis chr., pul., active	Unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison M. D. or other

R. M. CULLISON, M.D. CLIN. DIR.

Address: V.A.H. FORT HOWARD, MD. Date signed: 9-17-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

85

07767

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:
County: Baltimore
City or town: Owings Mills, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Rosewood State Training School
How long in hospital or institution? 10 yrs. 8 mo. 1 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Calvert
City or town: Dunkirk
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Thomas Buckler Jones

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept. 29, 1923

8. AGE: Years	Months	Days	If less than one day
23	11	22	hrs. min.

9. Birthplace: Unknown (Town, county, and state)
10. Usual occupation: Inmate: Rosewood State
11. Industry or business: Training School, Owings Mills Md.

FATHER
12. Name: James Buckler
13. Birthplace: Calvert Co.

MOTHER
14. Maiden name: Blanche Tucker
15. Birthplace: Calvert Co.

18. Informant: Institutional Records, Rosewood
Address: State Training School, Owings Mills Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept-23-47 (month) (day) (year)
Cemetery or crematory: ~~St Joseph~~ Woodlawn
Location: Balto.
18. Funeral director: John C Moran
Address: 3000 E Baltimore St

19. Sept-20 1947 (Date rec'd by registrar) Mary B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 20 19 47 at 9:15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 19 19 37 to Sept. 20, 19 47 and that I last saw him alive on Sept. 20, 19 47

Immediate cause of death	DURATION
Epileptic Convulsion	Immediat
Due to: Epilepsy	10 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op. None
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) NONE
Means of injury Injured at work?

23. SIGNATURE: George C. Medairy M. D.
M. D. or other
Address: Owings Mills, Md. Date signed 9/20/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07768

Reg. Dist. No. 80

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo. 16 days

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 1 mo. 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1620 Eutaw Place
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Jowanowitch, Steven

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Lou Jowanowitch

6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): May 27, 1907

8. AGE:

Years	Months	Days	If less than one day
40	3	29	....hrs. ....min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Repair Man

11. Industry or business: Allis Chalmers

FATHER
12. Name: Frank Jowanowitch
13. Birthplace: Hungary

MOTHER
14. Maiden name: Eva Horn
15. Birthplace: Hungary

16. Informant: Hospital Records
Address: Catonsville, Maryland

17. B. (Burial, cremation, or removal. Which?) Date thereof 9-26-47 (month) (day) (year)

Cemetery or crematory: Glen Haven

Location: Glen Burnie

18. Funeral director: James L. McCauley

Address: 1130 E. Fort Ave.

19. 9-25-47 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 23, 1947, at 5:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 7, 1947, to Sept. 23, 1947 and that I last saw him alive on September 23, 1947

	DURATION
Immediate cause of death: Acute myocardial failure;	12 hrs.
Due to: C. N. S. lues.	years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ....Date of op.....

Autopsy results: None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ....

Means of injury: ....Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. (M. D. or other)

Address: Spring Grove State Hospital Date signed: 9-23-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48a

07769

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County BALTIMORE
City or town SPARROWS POINT
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County BALTIMORE
City or town SPARROWS POINT
(If outside city or town limits, write RURAL and give nearest town)
Street No. 406 "F" STREET
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lona Garnett Julian

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	AFW	WIDOWED

6.(b) Name of husband or wife DONALD
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) JAN. 25, 1880

8. AGE: Years 67 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace WASHINGTON, INDIANA (Town, county, and State)

10. Usual occupation HOUSEWIFE

11. Industry or business OWN HOME

FATHER
12. Name (UNKNOWN) STEVENS
13. Birthplace INDIANA

MOTHER
14. Maiden name UNKNOWN
15. Birthplace INDIANA

16. Informant MRS. MILDRED HINES
Address 8531 ALLENTOWN RD. WASH D.C.

17. REMOVAL (Burial, cremation, or removal. Which?) Date thereof SEPT. 21, 1947 (month) (day) (year)
Cemetery or crematory OAK GROVE
Location WASHINGTON, INDIANA.

18. Funeral director WILLIAM COOK, INC.
Address 1217 ST. PAUL ST.

19. Sept 21 1947 (Date rec'd by registrar) Dawson L. Farber per R.E.F. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1947 at 7 37 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1947 to Sept 21 1947 and that I last saw him alive on Sept 20 1947

Immediate cause of death	DURATION
Carcinoma of vulva	—
Due to Carcinoma of cervix	1 Year
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE (M. D. or other)
Address 620 D St. Spa R 19 Date signed 9.21.47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

CERTIFICATE OF DEATH

07774

Reg. Dist. No. 43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Balto.

City or town: Perry Hall

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

Cross Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Perry Hall

(If outside city or town limits, write RURAL and give nearest town)

Street No. Cross Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Barbara C. Kahl

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Henry Kahl

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 12th 1869

8. AGE: Years	Months	Days	If less than one day
77			..... hrs. ..... min.

9. Birthplace: Balto. Co. Md. (Town, county, and state)

10. Usual occupation: at home

11. Industry or business

FATHER

12. Name: Joseph Noppenberger

13. Birthplace: Germany

MOTHER

14. Maiden name: Mary Miller

15. Birthplace: Germany

16. Informant: Mr. Jos. Kahl

Address: Loppa Rd. Fullerton

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 24th 1947 (month) (day) (year)

Cemetery or crematory: St. Josephs Cem.

Location: Balto. Co. Md.

18. Funeral director: Lansdowne Funeral Home

Address: 7401 Belair Rd.

19. Sept 21 1947 Mrs. A.L. Reifsnider

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 21st 1947, at 8:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 25, 1947, to Sept 21 1947

and that I last saw him alive on Sept. 20 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 hour
Due to: Cardio-Vascular Hypertension	5 years
Due to: Arteriosclerosis	5 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Michael J. Daresh M.D. (M. D. or other)

Address: 1 W. Overlea Ave. Date signed: 9/21/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940 07771

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:
County: Balto.
City or town: Lockhearn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, Institution, or street address where death occurred:
.....
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Lockhearn
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3609 Sylvan Drive
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME: MORELL HOFFMAN KEISTER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Sarah L. Keister
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): ~~Sep.~~ Dec. 15, 1886

8. AGE: Years	Months	Days	If less than one day
60	9	4	..... hrs. ..... min.

9. Birthplace: Balto., Md.
(Town, county, and state)
10. Usual occupation: Buyer
11. Industry or business: Stewart & Co.

FATHER
12. Name: William L. Keister
13. Birthplace: Md.

MOTHER
14. Maiden name: Mary Eliza Hoffman
15. Birthplace: Balto., Md.

16. Informant: Mrs. Sarah L. Keister
Address: 3609 Sylvan Drive

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9/23/47 (month) (day) (year)
Cemetery or crematory: Lorraine Cem.
Location: Woodlawn, Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md

19. 9/23/1947 (Date rec'd by registrar) W. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 19, 1947, at 6:00 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20 1947, to Sept 19 1947
and that I last saw him alive on 9-19-47 1947

Immediate cause of death	DURATION
Coronary Thrombosis	7 Weeks 2 Ds.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....
Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: C. B. Emson M. D. ~~or other~~
Address: 720 York Rd Balto 2. Date signed 9-21-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a 07772

Reg. Diat. No.

1. PLACE OF DEATH:
County Balto.
City or town Harrisonville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 days.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Harrisonville Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Liberty Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
Oliva Alice Klinefelter

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Aug 26. 1869

8. AGE: Years	Months	Days	If less than one day
78	—	22	... hrs. ... min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual occupation not emp.
11. Industry or business
FATHER 12. Name Gartman Klinefelter
13. Birthplace Balto.
MOTHER 14. Maiden name Oliva Klinefelter
15. Birthplace Balto.
16. Informant Mrs. J. Childs
Address 4606 Boarman ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 21. 1946 (month) (day) (year)
Cemetery or crematory Greenmount Cemetery
Location Greenmount ave. & Wooth Ave.
18. Funeral director John O. Mitchell & Sons Inc
Address 1606 Eutaw Place
19. Sept 19 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 18 19 47, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-18-'47 19 ... to 9-18-'47 19 ... and that I last saw her alive on not seen alive 19 ...

Immediate cause of death	DURATION
Coronary Occlusion	30 mins.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
NONE Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? NONE (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Dr. D. D. Caples Med. Exam. M. D. or other
Address Reisterstown, Md. Date signed 9-18-'47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

96

07773

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County: Balto.

City or town: Pikesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Mt. Wilson Lane

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Pikesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Mt. Wilson Lane

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

DR. ERNEST A. KNORR

3. (b) Social Security Number

--

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Elsie May Knorr (nee Everett) 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 5, 1875

8. AGE: Years	Months	Days	If less than one day
71	10	25	hrs. min.

9. Birthplace: Baltimore

(Town, county, and state)

10. Usual occupation: Physician

11. Industry or business

FATHER 12. Name: Charles J. Knorr

13. Birthplace: Baltimore, Md.

MOTHER 14. Maiden name: Clara Stuart

15. Birthplace: Balto., Md.

16. Informant: Mrs. Elsie May Knorr

Address: Mt. Wilson Lane, Pikesville

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/3/47 (month) (day) (year)

Cemetery or crematory: WOODLAWN CEM.

Location: Woodlawn, Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. Oct 3 19 47 (Date rec'd by registrar) C. W. Hedrick Registrar

28

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 30, 19 47, at 8:50p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 30 19 47 to September 30 19 47 and that I last saw him alive on September 30 19 47

Immediate cause of death	DURATION
Aortic Aneurysm	about 1 yr
Due to: Arterio sclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John D Bubert M.D. M. D. or other

Address: 4803 Park Heights Ave Date signed: 10/2/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Was not due to Syphilis —

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

07774

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Sparrows Point 19.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 years.
Hospital, institution, or street address where death occurred: Triple Union Park
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1802 Montford Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Fred J. Lang.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Amelia.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 15th, 1883

8. AGE:

Years	Months	Days	If less than one day
64	4	9	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Blacksmith
11. Industry or business: Mt. Clare, B & O R.R.

FATHER
12. Name: Christian Lang
13. Birthplace: Germany

MOTHER
14. Maiden name: Mary Schwartzenburg
15. Birthplace: Germany

16. Informant: Mrs. Augusta Foerster
Address: 1802 N. Montford Ave.

17. burial (Burial, cremation, or removal. Which?) Date thereof 9/27/47 (month) (day) (year)
Cemetery or crematory: Immanuel
Location: Baltimore, Md.

18. Funeral director: Lassahn Funeral Home
Address: 7401 Belair Rd.

19. Sept 30 19 47 (Date rec'd by registrar) Dawson L. Farber, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 24 19 47, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral accident	Sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. McCarmon M.D.
M.D. or other
Deputy medical Examiner
Address: Baltimore Md. Date signed 9/24/47.

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93e

07775 f.

Reg. Dist. No. 42

1. PLACE OF DEATH:

County Baltimore

City or town Halethorpe

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yr

Hospital, institution, or street address where death occurred:

How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Baltimore

City or town Halethorpe

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5600 Selma Ave

(If rural, give LOCATION)

2.(a) If veteran, name war -

3. (a) FULL NAME Mrs. Margaret Eo. Leigh

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Frederick C. Leigh

6.(c) If alive, give age deceased years

7. Birth date of deceased (mo., day, yr.) Dec 15 - 1869

8. AGE: Years	Months	Days	If less than one day
77	8	28	✓ hrs. ✓ min.

9. Birthplace Baltimore - Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business -

FATHER

12. Name Horace T. Beckwith

13. Birthplace Balto, Md.

MOTHER

14. Maiden name Margaret Hayes

15. Birthplace Balto Md.

16. Informant Ernest Leigh

Address 5600 Selma Ave - Sy

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof SEPT. 16 - 1947 (month) (day) (year)

Cemetery or crematory LOUDON PARK

Location -

18. Funeral director Chas. L. Cramer's Son Inc.

Address 118 W. Mt. Royal Ave.

19. Sept 15 1947 (Date rec'd by registrar) C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17 1947, at 7:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942, to Sept 17 - 1947

and that I last saw h.. alive on Sept 14 - 1947

Immediate cause of death ..... DURATION

Coronary thrombosis - Angina 6 yrs.

Due to Hypertension - Arteriosclerosis

Due to Senility 1 year

Other conditions ✓

(Include pregnancy within 3 months of death)

Major findings of operations -

Date of op. -

Autopsy results ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) -

Means of injury Injured at work?

23. SIGNATURE Frederick V. Beitler M. D. or other

Address 1014 Francis Ave. Balto 17 Date signed 9-12-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(I)

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

07776

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Balto
City or town: Colgate
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 7940 Eastern Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Colgate
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7940 Eastern Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: John M. Lowrey

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	married

6.(b) Name of husband or wife: Marie (Hartman)
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug - 18 - 1863

8. AGE: Years	Months	Days	If less than one day
84		25	..... hrs. ..... min.

9. Birthplace: Balto Co. Md
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business
FATHER 12. Name: Charles Lowrey
13. Birthplace: Balto
MOTHER 14. Maiden name: Mc Elroy
15. Birthplace: Pa.
16. Informant: Mrs. Marie Lowrey
Address: 7940 Eastern Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 16-47 (month) (day) (year)
Cemetery or crematory: Oak Lawn
Location: Eastern Ave & Rd
18. Funeral director: John B. Connelly
Address: 418 Eastern Ave.
19. Sept. 15 1947 (Date rec'd by registrar) John B. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 13 1947 at 4:00 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13th 1947 to Sept. 13 1947 and that I last saw h-- alive on Sept. 13 1947

Immediate cause of death	DURATION
Arterio-sclerotic Cardio-Vascular Disease	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: no
Date of op.
Autopsy results: no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James F. White, M.D.
M. D. or other
Address: 7601 Eastern Ave, Baltimore 24, Md. Date signed: 9/15/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07777

69

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH:
County: Baltimore
City or town: Raspeburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, Institution, or street address where death occurred:
Trump Mill Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto. Co.
City or town: Raspeburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Trump Mill Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: MARGARET LUTZ

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: George W. Lutz
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 4th, 1868

8. AGE:	Years	Months	Days	If less than one day
	79	3	5	..... hrs. ..... min.

9. Birthplace: Balto. Co., Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Valentine Hillen
13. Birthplace: Balto. Co., Md.

MOTHER
14. Maiden name: Julia - -
15. Birthplace: unknown

16. Informant: Mrs. Julia M. Pfeifer,
Address: Trump Mill Rd., Raspeburg, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof Sept. 12, 1947 (month) (day) (year)

Cemetery or crematory: Zion Luthern
Location: Stemmers Run, Md.

18. Funeral director: Lansdale Funeral Home
Address: 7401 Belair Road

19. Sept 10 - 1947 (Date rec'd by registrar) Mrs. A. L. Reifsnider Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 9 1947, at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March, 1946, to Sept 8 1947

and that I last saw h... alive on ..... 19...

Immediate cause of death	DURATION
Cardiac failure	2 mos
Pulmonary edema	
Due to Arteriosclerotic & hypertensive cardiac disease	3 yrs
Due to	
Other conditions Pellagra	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. H. Fuller M.D. M. D. or other

Address: Ridge Rd. Balt-6 Md. Date signed Sept 8/47

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

07778

CERTIFICATE OF DEATH

Reg. Diat. No. .....

1. PLACE OF DEATH:

County Baltimore

City or town Woodstock
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:
Davis Ave.

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Woodstock
(If outside city or town limits, write RURAL and give nearest town)

Street No. Davis Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Frederick Matthes

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Anna Matthes

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 18, 1868

8. AGE: Years	Months	Days	If less than one day
79	-	21	..... hrs. ..... min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation Retired Blacksmith

11. Industry or business

FATHER 12. Name Mr. Matthes

13. Birthplace Germany

MOTHER 14. Maiden name Unknown

15. Birthplace Germany

16. Informant Mr. Harry Matthes

Address Davis Ave., Granite, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 12, 1947 (month) (day) (year)

Cemetery or crematory Mt. Olive Cemetery

Location Randallstown, Md.

18. Funeral director J. W. Cameron

Address 4510 Liberty Heights Ave.

19. 9/11 1947 J. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 9 1947 at 5 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 9-9-'47 19.. to 9-9-'47 19..

and that I last saw him alive on not seen alive 19..

Immediate cause of death	DURATION
Coronary Occlusion	Instant
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operation NONE Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? NONE (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Dr. D. D. Eagler, Med. Exam. M. D. or other

Address Reisterstown, Md. Date signed 9-9-'47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07779 P

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years, 23 days

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 2 years, 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3102 Juneau Place
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Lewis Turner Medinger

3.(b) Social Security Number: 218-12-6658

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Maggie May Kagel Medinger

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): February 24, 1871

8. AGE: Years	Months	Days	If less than one day
76	6	22	____ hrs. ____ min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: Carpentering

MOTHER FATHER

12. Name: John G. Medinger

13. Birthplace: Maryland

MOTHER

14. Maiden name: Marguerette Schminter

15. Birthplace: Maryland

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/19/47 (month) (day) (year)

Cemetery or crematory: Woodlawn Cem.

Location: Woodlawn, Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. Sept 18 1947 (Date rec'd by registrar) a. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 16 1947, at 12:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____

and that I last saw h____ alive on ____ 19____

Immediate cause of death	DURATION
Acute cardiac failure	
Due to: Cardio vascular disease	
Due to: fracture right femur	
Other conditions: due to fall on floor	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of (injury) Aug 30 47

Where did injury occur? Catonsville (City or town) Balto (County) Md (State)

Injured at home, farm, industry, public place (where?): hospital

Means of injury: had a fall on the floor Injured at work? no

23. SIGNATURE: Geo. M. Kieffer Dep. Med. Exam. M.D. or other

Address: 1010 Leeds Ave. Date signed: Sept 16, 47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information called for. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

change of year of birth evidence is shown on Film G114 3/8/48 js

Evidence for change of wife's age shown on Film G114 3/18/48 dm Baptismal Record of Wife and Marriage Record

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07780

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County: Baltimore

City or town: Pikesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Pikesville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 18 Waldron Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Newton Mitchell Mercier

3. (b) Social Security Number: 214-01-7842

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

8.(b) Name of husband or wife: Cecilia M. Mercier

8.(c) If alive, give age: 1946 48 years

7. Birth date of deceased (mo., day, yr.): Nov. 7- 1898

8. AGE:

Years	Months	Days	If less than one day
49	9	28	... hrs. ... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Insurance

11. Industry or business: Felix R. Sullivan Co.

FATHER

12. Name: George Mercier

13. Birthplace: Howard Co. Maryland

MOTHER

14. Maiden name: Emma McGinnis

15. Birthplace: Frederick, Maryland

16. Informant: Mrs. Cecilia M. Mercier

Address: 18 Waldron ave. Pikesville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 5-1947 (month) (day) (year)

Cemetery or crematory: Druid Ridge

Location: Pikesville, Maryland

18. Funeral director: Frank H. Meurel

Address: Pikesville, Maryland

19. 9-4-1947 (Date rec'd by registrar) E. E. Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 2 1947, at 6.30 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 1st 1945 to Sept. 2nd 1947

and that I last saw h... alive on Sept. 2nd 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 day.
Due to: Hypertension	2 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: James A. Miller M. D. (M. D. or other)

Address: Pikesville, Md. Date signed: 9/4/47.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 932

07787

1. PLACE OF DEATH:
County: Baltimore Co., Maryland
City or town: 3525 S. James Road, Rockdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months
Hospital, Institution, or street address where death occurred:
3525 St. James Road, Rockdale, Balto. Co., Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2023 Maryland Avenue, Balto. Md.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Eugenie duMaurier Meredith

3.(b) Social Security Number: None

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Clyde R. Meredith
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): June-13-1876
8. AGE: Years: 71 Months: 2 Days: 25 If less than one day ... hrs. ... min.
9. Birthplace: Pottsville, Penna. (Town, county, and state)
10. Usual occupation: None
11. Industry or business:
12. FATHER Name: Thomas duMaurier
13. FATHER Birthplace: Pottsville, Penna.
14. MOTHER Maiden name: Mary Ellen Moyer
15. MOTHER Birthplace: Pottsville, Penna.
16. Informant: Mr. Clyde R. Meredith (husband)
Address: 2023 Maryland Ave., Baltimore, Md.
17. Burial (Burial, cremation, or removal. Which?) Friends Burying Ground thereof Sept-10-1947 (month) (day) (year)
Cemetery or crematory: Friends Burying Ground
Location: Baltimore, Maryland
18. Funeral director: Stewart & Mowen Company
Address: 108 W. North Avenue, City #1.
19. 9/9 (Date rec'd by registrar) 1947 J. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 8th 1947 at 3.45 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 7th 1947 to Sept. 8th 1947 and that I last saw h.e.r. alive on Sept. 7th 1947

	DURATION
Immediate cause of death: Chronic Myocarditis	3mons
Due to: Coronary Sclerosis	3mons
Due to: Art. Sclerosis	1yr.
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: James G. Miller M.D. M. D. or other
Address: Pikesville, Md. Date signed: 9/8/47.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS/A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

07782

Reg. Diat. No. 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 106 Shadymoor Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balt.

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 106 Shadymoor Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3. (a) FULL NAME: Benjamin Lacy Mettee

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Ethel Rudolph Mettee

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 7, 1893

8. AGE:

Years	Months	Days	If less than one day
54	4	22	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Interior decorator

11. Industry or business

FATHER 12. Name: Charles Andrew Mettee

13. Birthplace: Md.

MOTHER 14. Maiden name: Anastatia Emrick

15. Birthplace: Md.

16. Informant: Benjamin Mettee, Jr.

Address: 106 Shadymoor Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-7-47 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Baltimore

18. Funeral director: George A. Farley

Address: Shadymoor & Frederick Ave.

19. 10/7/47 19..... (Date rec'd by registrar) J. C. Mommonier per T Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 29 1947, at 8:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 13 1935, to Oct 29 1947 and that I last saw him alive on Oct 11 1947

Immediate cause of death	DURATION
Coronary occlusion & Diabetes	Indefinite
Due to	
Due to	
Other conditions Coronary Thrombosis & Myocarditis (include pregnancy within 3 months of death)	8/5/46

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Eliot W. Johnson M. D. or other

Address: 3432 Frederick Ave. Date signed 10/8/47

COPY SENT TO CNO. DATE 10/3/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d 07783

Reg. Dist. No. 41

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Dundalk

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Dundalk

(If outside city or town limits, write RURAL and give nearest town)

Street No. 98 Kentway

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Polly Brook Mitchell

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: Harry Mitchell

8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1888

8. AGE: Years	Months	Days	If less than one day
59			hrs. min.

9. Birthplace: England (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: James Brook

13. Birthplace: England

MOTHER — 14. Maiden name: Ellen --------

15. Birthplace: England

16. Informant: Mr. Harry Mitchell

Address: 98 Kentway, Dundalk 22, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Sept. 24, 1947 (month) (day) (year)

Cemetery or crematory: Church of the Redeemer

Location: Bryn Mawr, Penna.

18. Funeral director: Roland L. Fisher

Address: 2112 Dundalk Ave.

19. 9/23/47 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 21 1947 at 11:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15th 1947, to Sept 21 1947, and that I last saw her alive on Sept. 19th 1947.

Immediate cause of death	DURATION
Hypertensive C-V-Disease	- 5 yrs.
Due to: c Myocardits.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: Dundalk-22 Date signed: 9/23/47

07784

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1246

CERTIFICATE OF DEATH

Reg. Dist. No. 2002

1. PLACE OF DEATH:
County: Baltimore
City or town: Rockdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
3515 St. James Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Rockdale
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3515 St. James Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Rosina Morningstar

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Charles P. Morningstar
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): August 28, 1868

8. AGE: Years	Months	Days	If less than one day
79	-	10	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: None
11. Industry or business

FATHER
12. Name: George Bichmann
13. Birthplace: Germany

MOTHER
14. Maiden name: Rosina Mohr
15. Birthplace: Germany

16. Informant: Mrs. Alfred W. Strahan
Address: 3515 St. James Rd., Rockdale

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 10, 1947 (month) (day) (year)
Cemetery or crematory: Loudon Park Cemetery
Location: Baltimore, Md.
18. Funeral Director: Hobbs Lamotte
Address: 4510 Liberty Heights Ave.
19. 9/10 19 47 A. W. Strahan Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 8 19 47, at 1.45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 11th 19 46 to Sept 8th 19 47
and that I last saw her alive on Sept 7th 19 47

Immediate cause of death	DURATION
Cirrhosis of Liver	1 yr.
Due to: Art. Sclerosis	5 yrs
Due to: Hypertension	9 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: James A. Miller M. D. or other
Address: Reisterstown Rd & Walker Ave Pikesville, Md. Date signed 9/8/47.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164a

07785

CERTIFICATE OF DEATH

Reg. Dist. No. 41

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH.

County: Balto.

City or town: Dundalk 22

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred: #11 Dundalk apts

How long in hospital or institution? 2 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Balto.

City or town: Dundalk 22

(If outside city or town limits, write RURAL and give nearest town)

Street No.: #11 Dundalk apts.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Rosina Johnson Moore

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	White	Married Separated

6.(b) Name of husband or wife: Geo. Moore

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 18, 1879

8. AGE:

Years	Months	Days	If less than one day
68	5	29	hrs. min.

9. Birthplace: Maryland (Town, county and state)

10. Usual occupation: Housework

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden name

15. Birthplace

16. Informant: Mrs Paul Cupp

Address: 6842 Beldare Road, Dundalk

1T. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 20, 1947 (month) (day) (year)

Cemetery or crematory: Lorraine Park Cemetery

Location: Woodlawn, Balto. Co.

18. Funeral director: Roland L. Fisher

Address: 2112 Dundalk Ave.

19. 9/19/47 19. W M Carmine

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 17 1947, at 6 30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 17 1947, to 19

and that I last saw h alive on 19

Immediate cause of death: Strangulation by hanging. DURATION

Due to: (Probably 9/16/47.)

Due to: Found hanging in clothes closet from

Other conditions: rod.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of 9/16/47

Where did injury occur? Dundalk, Balto. Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Scarf around neck Injured at work? no.

23. SIGNATURE: W M Carmine M.D. Deputy Medical Examiner (M.D. or other)

Address: Dundalk 22 Date signed: 9/17/47.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d 130

07786

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County: Baltimore

City or town: Owings Mills

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs 5 mos. 11 days

Hospital, institution, or street address where death occurred: Rosewood State Training School

How long in hospital or institution? 15 yrs 5 mos. 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: —

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1600 Cliftview Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Elsie Marcell Moorehead.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 14, 1920.

8. AGE:

Years	Months	Days	If less than one day
27	7	16	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Inmate.

11. Industry or business: —

FATHER

12. Name: Winston Moorehead.

13. Birthplace: Baltimore Maryland

MOTHER

14. Maiden name: Lavinia Wesley

15. Birthplace: Maryland.

16. Informant: Rosewood State School Records

Address: Owings Mills, Md.

17. Burial, cremation, or removal. Which? Burial Date thereof: 10/4/47 (month) (day) (year)

Cemetery or crematory: Baltimore

Location: Baltimore Md.

18. Funeral director: Wilson Bros Inc

Address: 1219 E Pratt St

19. Oct 1 1947 A. W. Hedrick Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 30 1947, at 2 40 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 1 1947, to Sept 30 1947

and that I last saw h[illegible] alive on September 30 1947.

Immediate cause of death	DURATION
Acute myocarditis	2 days.
Due to: Chronic Myocarditis	8 yrs +.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Isabel H. McClinton M.D.

M. D. or other

Address: Rosewood, Owings Mills, Md. Date signed: Sept. 30, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

18c

07787

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mos.

Hospital, Institution, or street address where death occurred: 16 Fusting Ave.

How long in hospital or institution? 6 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: none

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2846 N. Calvert St.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Martha B. Morrow

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 18, 1872

8. AGE: Years	Months	Days	If less than one day
75	1	20	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER — 12. Name: James S. Morrow

13. Birthplace: Baltimore, Md.

MOTHER — 14. Maiden name: Lydia A. Fogelman

15. Birthplace: Ohio

16. Informant: James S. Morrow, Jr.

Address: 249 Ridge Ave., Towson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/10/47 (month) (day) (year)

Cemetery or crematory: Woodlawn

Location: Woodlawn, Md.

18. Funeral director: John O. Mitchell & Sons, Inc.

Address: 1900 Eutaw Place, Baltimore, Md.

19. 9/8 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 7 19 47, at 9.30a. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 21 19 47, to September 6 19 47 and that I last saw h.. alive on SEPT 5 19 47

Immediate cause of death	DURATION
Metastatic Ca of Brain + Emp.	4 mo
Due to: Ca of Uterus	1 year
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Wilmer K. Gallagher, M.D. M. D. or other

Address: 6209 Frederick Ave. Date signed: 9-8-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07788

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore - 30 -
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1148 Cooksie Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

Louis Nickel

3.(b) Social Security Number

215 - 09 - 3205

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna ~~Spickala~~ Korowski

6.(c) If alive, give age: 31 years

7. Birth date of deceased (mo., day, yr.): February 12, 1907

8. AGE: Years	Months	Days	If less than one day
40	7	10	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and State)

10. Usual occupation: Unknown

11. Industry or business: "

FATHER 12. Name: Walter Nickel

FATHER 13. Birthplace: Poland

MOTHER 14. Maiden name: Anna Spickala

MOTHER 15. Birthplace: Poland

16. Informant: Hospital Records

Address: Catonsville, 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sep 26/47 (month) (day) (year)

Cemetery or crematory: St Stanislaus

Location: Balto. City

18. Funeral director: John M. Weber

Address: 401 S. Chester Street

19. Sept 24 19 47 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 22, 1947 19 at 3:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 18 1947 to September 22 1947 and that I last saw him alive on September 22, 1947 19

Immediate cause of death	DURATION
Bilateral lobar pneumonia	4 days
Due to: Chronic interstitial nephritis --	Indefinite
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M. D.
M. D. or other

Address: Catonsville, 28, Md. Date signed: 9/22/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07789

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Hood Nursing Home, 5501 Edmondson Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3049 Brighton St.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Genevieve A. O'Brien

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 4, 1875

8. AGE: Years	Months	Days	If less than one day
72	6	4	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Daniel E. O'Brien
13. Birthplace: Ireland

MOTHER
14. Maiden name: Mary Elizabeth Curran
15. Birthplace: Ireland

16. Informant: Mr. Jesse C. Gawthrop
Address: 3049 Brighton St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 9, 1947 (month) (day) (year)

Cemetery or crematory: New Cathedral Cemetery

Location: Baltimore, Md.

18. Funeral director: Thelis Lawrence

Address: 4810 Liberty Heights Ave.

19. 9/8/47 (Date rec'd by registrar) 19 ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 7 19 47, at 9.15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar - 7 19 47, to Sept 7 19 47 and that I last saw her alive on Sept 6 19 47

Immediate cause of death	OURATION
Ulcer Myocardiitis	6 mon
Due to Arterio Sclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jesse Gawthrop M. D. or other

Address: 715 Frederick Ave., Catonsville, Md. Date signed 9-8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

07790

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:
County: Balto Co Md.
City or town: Glenarm Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Glenarm
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: William S. Pearce

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 19 — 1878

8. AGE: Years 68 | Months 9 | Days 15 | If less than one day ..... hrs. ..... min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business

FATHER
12. Name: Brentbury Pearce
13. Birthplace: Md.

MOTHER
14. Maiden name: Martha J. Sinn
15. Birthplace: Md.

16. Informant: Louis Pearce
Address: Glenarm Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof Sept. 6-47 (month) (day) (year)
Cemetery or crematory: Waugh Chapel Cem
Location: Glenarm Md.

18. Funeral director: Clarence E. Arthur
Address: Fork Md.

19. Sept 6 1947 (Date rec'd by registrar) Clarence E. Arthur Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 4, 1947, at 5:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 22 1947 to Sept 4 1947 and that I last saw h alive on Sept. 4, 1947

Immediate cause of death: Cerebral Hemorrhage — DURATION: 4 4½ mo.
Due to: Hypertension — 3yrs.
Due to: Arteriosclerotic Disease
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Clifford F. Hudson M.D.
M. D. or other
Address: Fork Md. Date signed: 9/5/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Dr. Abbott
Hillsdale &
Liberty Heights

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

07791

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Haywood Heights 3606 Tulsa Rd.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution? 3606 Tulsa Road

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Haywood Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3606 Tulsa Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: William Thomas Pfeiffer

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret A. Pfeiffer
6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): Sept. 20, 1859

8. AGE: Years	Months	Days	If less than one day
87	11	18	hrs. min.

9. Birthplace: Baltimore County, Md. (Town, county, and state)
10. Usual occupation: Real Estate
11. Industry or business:

FATHER
12. Name: Frederick Pfeiffer
13. Birthplace: Germany

MOTHER
14. Maiden name: Elizabeth Collins
15. Birthplace: Unknown

16. Informant: Mrs. William T. Pfeiffer
Address: 3606 Tulsa Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 9, 47 (month) (day) (year)
Cemetery or crematory: Cathedral
Location: Baltimore, Md.

18. Funeral director: Ellsworth Armacost
Address: 3911 Liberty Heights Ave.

19. 9/8 (Date rec'd by registrar) 19 47 [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 7 19 47, at 330 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 19 44, to Sept - 7 - 19 47 and that I last saw h[illegible] alive on Sept 6th 19

Immediate cause of death	DURATION
Senium Senility Old age	
Due to Chronic Nephritis	
Due to Chronic Myocarditis	
Due to Generalized Arteriosclerosis	—
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Thos. J. Abbott M.D. M. D. or other
Address: 4509 Liberty Heights Ave. Date signed 9-8-47

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a 07792

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town Hampstead Route #2
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1312 Morling Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war --

3.(a) FULL NAME Emma E. Plowman

3.(b) Social Security Number --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 6, 1868

8. AGE: Years	Months	Days	If less than one day
79	2	11	..... hrs. ..... min.

9. Birthplace Carroll Co. Maryland
(Town, county, and state)
10. Usual occupation Practical Nurse
11. Industry or business

FATHER
12. Name Andrew Plowman
13. Birthplace Maryland

MOTHER
14. Maiden name Margaret Hager
15. Birthplace Maryland

16. Informant Mrs. Maggie McCarthy
Address 1312 Morling Ave. Baltimore

17. Burial (Burial, cremation, or removal. Which?) Date thereof September 20, 1947 (month) (day) (year)
Cemetery or crematory St. Mary's (Hampden)
Location Baltimore, Maryland

18. Funeral director Burgee Funeral Home
Address 3631 Falls Road, Baltimore 11

19. 9/19 (Date rec'd by registrar) 19 47 A. M. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17 19 47 at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-17-'47 19 to 9-17-'47 19 and that I last saw her alive on not seen alive 19

Immediate cause of death	DURATION
Coronary Occlusion	Approx. 15 mins.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations NONE Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? NONE (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Dr. D. D. Eagles Med. Exam. M. D. or other
Address Reisterstown, Md. Date signed 9-17-'47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

163-F

07793

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH:
County Balto.
City or town Overlea.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred Transit Sta. Waiting Sta.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Phosphura P.O.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Belair Rd. Fullerton.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Frederick Henry Reider.

3. (b) Social Security Number 213-10-0170

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9th, 1898

8. AGE: Years	Months	Days	If less than one day
49	2	10	hrs. min.

9. Birthplace Baltimore County, Md. (Town, county, and state)
10. Usual occupation Barn Man
11. Industry or business Baltimore Transit Co.

FATHER
12. Name Frederick Reider
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden name Maggie F. Besold
15. Birthplace Baltimore County, Md.

16. Informant Mrs. Maggie Reider
Address Belair Rd. Fullerton P.O.

17. burial (Burial, cremation, or removal. Which?) Date thereof 9/22/47 (month) (day) (year)
Cemetery or crematory Parkwood
Location Taylor Ave.

18. Funeral director Lassahn Funeral Home.
Address 7401 Belair Rd.

19. Sept 20 1947 Mrs. G. L. Reforniter Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1947, at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 19 1947 to — 19
and that I last saw him alive on 19

Immediate cause of death	DURATION
Phenobarbital Poisoning	
Due to (Overdose)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Suicide. Date of 9/19/47
Where did injury occur? Overlea. (City or town) Balto. (County) Md. (State)
Injured at home, farm, industry, public place (where?) Public Place
Means of injury Phenobarbital Injured at work? No.

23. SIGNATURE W. M. Learning M.D.
Deputy Medical Examiner
Address Towson 4, Md. Date signed 9/19/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932 07794

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1310 Midvale Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Harry L. Robison

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Edith

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 27, 1887

8. AGE: Years	Months	Days	If less than one day
59	11	26	hrs. min.

9. Birthplace: Ohio (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: Gunther Hardware Co.

FATHER — 12. Name: Franklin Robison

FATHER — 13. Birthplace: Ohio.

MOTHER — 14. Maiden name: Lois Hart

MOTHER — 15. Birthplace: Ohio.

16. Informant: Mrs Edith Robison

Address: 1310 Midvale Ave.

17. (Burial, cremation, or removal. Which?) Burial Date thereof: Sept 25, 1947 (month) (day) (year)

Cemetery or crematory: Western

Location: Edmondson Ave & Longwood Sts

18. Funeral director: Harry H. Wittke

Address: 4101 E Edmondson Ave.

19. Sept 24 1947 (Date rec'd by registrar) H. W. Gadrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 23 1947 at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 10 1947 to Sept. 23 1947 and that I last saw him alive on September 20 1947

Immediate cause of death	DURATION
Acute Cardiac Dilatation	8 Min.
Due to: Chronic Auricular Fibrillation	2 yr.
Due to: Chronic Cardio-Vascular disease	6 yr.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: William K. Gallagher M.D. M. D. or other

Address: Catonsville, Md. Date signed 9-24-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

520

CERTIFICATE OF DEATH

Reg. Dist. No. 07795

1. PLACE OF DEATH:

County Balto.

City or town Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Annacost Nursing Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No. York Rd. & Seminary Ave. Lutherville

(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME HENRY ROCKEL

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Lorretta M. Rockel

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1877

8. AGE: Years	Months	Days	If less than one day
69	9	22	..... hrs. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER — 12. Name George R. Rockel

13. Birthplace Balto. Md.

MOTHER — 14. Maiden name Catherine Tantz

15. Birthplace Balto. Md.

16. Informant Mr. Roland A. Rockel

Address Lutherville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/1/47 (month) (day) (year)

Cemetery Jessops Cem.

Location Cockeysville, Md.

18. Funeral director WM. J. TICKNER & SONS INC.

Address North & Pa. Aves. Balto. 17, Md.

19. 9-30 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28, 1947, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 16 1947 to Sept 28 1947 and that I last saw h.. alive on Sept 28 1947

Immediate cause of death	DURATION
Hypernephroma	2 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Hypernephroma left Kidney Date of op. 1946

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE C. K. Reier M.D. (M. D. or other)

Address 6201 York Rd Date signed 29 Sept 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 38

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Co.
(a) Baltimore City, Maryland
(b) Street address Towson, Md.
(c) Hospital or institution:
front of Blacker Decker Mfg. Corp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: 07796
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 535 Cumberland St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jerome W. Rollins

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-22-8122

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Minnie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1901

8. AGE: Years	Months	Days	If less than one day
46			hr. min.

9. Birthplace Elkridge, Md.
(Town, county, and state)

10. Usual Occupation Shipping clerk.

11. Industry or business

FATHER
12. Name Francis Rollins
13. Birthplace Howard Co. Md.

MOTHER
14. Maiden Name James Rollins
15. Birthplace Howard Co. Md.

16 (a) Informant Mrs. Minnie A. Rollins
(b) Address 535 Cumberland St.

17 (a) Burial (b) Date thereof Sept. 27 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Family lot
Location Elkridge, Md.

18 (a) Funeral director Chas. H. Hollan
(b) Address 16 W. Pond Hill Ave

19 (a) Sept 25 47 [illegible] Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24 1947, at 4 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Syphilitic aortitis
Syphilitic heart disease
Due to Pulmonary edema

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 9/24/47

VS 151

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a

07797

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years, 10 months

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 3 years, 10 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2115 North Charles Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Elsie Ellen Roop

3.(b) Social Security Number: 219-05-7577

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: William W. Roop

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 18, 1874

8. AGE: Years: 72 | Months: 8 | Days: 17 | If less than one day: hrs. min.

9. Birthplace: Philadelphia, Pennsylvania
(Town, county, and state)

10. Usual occupation: dressmaker

11. Industry or business: clothing (Employer-Shane Russell)

FATHER
12. Name: James H. Shawn
13. Birthplace: Delaware

MOTHER
14. Maiden name: Avis Smith
15. Birthplace: Delaware

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/8/47 (month) (day) (year)

Cemetery or crematory: Loudon Park Cem.

Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 9/8 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 5 1947 at 7:30 p. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 5 1943 to September 5 1947 and that I last saw her alive on September 5 1947

Immediate cause of death	DURATION
Myocardial decompensation	2 days
Due to: Chronic hypertensive cardio-vascular-renal disease	years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

Isadore Tuerk

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed: 9-6-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157d 07798 33

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Baltimore

City or town Owings Mills, Maryland (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since Dec. 10, 1935

Hospital, Institution, or street address where death occurred:
Rosewood State Training School

How long in hospital or institution? Since Dec. 10, 1935

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Owings Mills
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rosewood State Training School
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Daniel Rosenthal

3. (b) Social Security Number .....

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 10-9-29

8. AGE:

Years	Months	Days	If less than one day
17	11	15	..... hrs. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business .....

FATHER
12. Name Samuel Rosenthal
13. Birthplace Russia

MOTHER
14. Maiden name Anna Gorelick
15. Birthplace Russia

16. Informant Hosp. Records
Address .....

17. Burial (Burial, cremation, or removal? Which?) Date thereof 9-26-47 (month) (day) (year)

Cemetery or crematory Rosedale

Location Phila Rd & Hamilton Ave

18. Funeral director Jack Lewis Inc

Address 2600 Eutaw Place

19. Sept 26 1947 (Date received by registrar) a. w. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 26, 1947, at 2:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September, 1943, to Sept. 26, 1947 and that I last saw him alive on Sept. 25, 1947

Immediate cause of death	DURATION
Epilepsy	17 yrs 11 mos
Due to Congenital malformation of the brain - spastic quadraplegia	17 yrs 11 mos
Due to	.....
Other conditions Diabetes	4 mos.

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the csuse to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury ..... Injured at work?

23. SIGNATURE Viola Barrett Johns, M. D.
M. D. or other

Address Rosewood, Owings Mills, Md. Date signed 9/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

48a

07799 P.

CERTIFICATE OF DEATH

Reg. Diat. No. 43

1. PLACE OF DEATH:
County Baltimore
City or town Raspburg, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Raspburg, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Trump Mill Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Pauline Pearl Sain (PAULINE PEARL SAIN)

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife George D. Sain
6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) April 29, 1897

8. AGE: Years	Months	Days	If less than one day
50	4	6	hrs. min.

9. Birthplace Manassas, Va. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Calvin Thomassan
13. Birthplace Va.

MOTHER
14. Maiden name ? wedrick
15. Birthplace Va.

16. Informant George D. Sain - husband
Address Trump Mill Rd. Raspburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/7/47 (month) (day) (year)
Cemetery or crematory Valley View Cemetery
Location Manassas, Va.

18. Funeral director HENRY SANDER & SONS, INC.
Address NORTH AVE. & BROADWAY

19. 9/4/47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 19 47, at 7 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 19 47, to Sept 4 19 47 and that I last saw her alive on Sept 4/47 19

Immediate cause of death	DURATION
Toxemia.	6 mos
Due to Carcinoma of Cervix	1 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Geo M. Baumgardner M. D. or other
Address Balto 6 Md Date signed 9-4-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of age and birthdate is shown on G 112 9/8/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

078114 93d

Reg. Diat. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
135 Newburg Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 135 Newburg Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Amelia F. Schafer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Clyde W. Schafer
6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): September 3, ~~1888~~ 1887

8. AGE: Years	Months	Days	If less than one day
59 ~~58~~	11	29	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At Home
FATHER 12. Name: William F. Foos
13. Birthplace: Baltimore, Md.
MOTHER 14. Maiden name: Mary Heinz
15. Birthplace: Baltimore, Md.
16. Informant: Mr. Clyde W. Schafer
Address: 135 Newburg Ave., Catonsville
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 5, 1947 (month) (day) (year)
Cemetery or crematory: Loudon Park Cemetery
Location: Baltimore, Md.
18. Funeral director: Miller Lawrence
Address: 4510 Liberty Heights Ave.
19. 9/3/47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 2 19 47 at 10 P. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 19 47 to Sept. 2 19 47
and that I last saw her alive on Sept. 2 19 47

Immediate cause of death	DURATION
Acute Myocardial Infarction	1 hr.
Due to Arteriosclerotic cardio-vas disease	2 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John Z. Bowers M. D. or other
Address: 20 E. Preston St. Date signed: Sept. 3, 1947

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

8304

07801

Reg. Dist. No. 43

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
County: Balto.
City or town: Parkville P.O.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 9017 Hartford Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Fullerton P.O. Carney
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D. 6 Joppa Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John Edward Schneider
3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary Elizabeth.
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Sept 22/1872

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
75	0	8		

9. Birthplace: Balto. Co. Md.
(Town, county, and state)
10. Usual occupation: Carpenter.
11. Industry or business:

FATHER — 12. Name	John A. Schneider
FATHER — 13. Birthplace	U.S.A.
MOTHER — 14. Maiden name	Unknown
MOTHER — 15. Birthplace	Balto. Co., Md.

16. Informant: John Edw. Schneider Jr.
Address: Stone. Carney.
17. buried (Burial, cremation, or removal. Which?) Date thereof: Oct. 3, 1947 (month) (day) (year)
Cemetery or crematory: St. Johns Lutheran
Location: Parkville, Md.
18. Funeral director: Lovalow Funeral Home
Address: 7401 Belair Rd. Balto 6, Md.
19. Oct. 1 - 1947 Mrs. A. L. Reisinger
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 30 1947, at 11 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 30 1947, to 19; and that I last saw alive on 19

Immediate cause of death	DURATION
Cerebral accident	Instn.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. M. Carney M.D.
M.D. or Other
Deputy medical Examiner
Address: Davidsonville Md. Date signed: 9/30/47.

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

EVIDENCE SHOWN ON FILM No. G 112 SEP 30 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

07811

8

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH:

County: Balto. Co.

City or town: Balto. Roseberry

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 4410 Belmore Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Balto

City or town: Balto.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 3048 Woodside Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Jos H. Snider (Schneider)

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	

6.(b) Name of husband or wife: Mary

6.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): Sept 20

8. AGE: Years: 80 Months: Days: If less than one day: hrs. min.

9. Birthplace: Shrewsbury Pa (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER

12. Name: Unknown

13. Birthplace

MOTHER

14. Maiden name: Unknown

15. Birthplace

16. Informant: Mrs Paul R. Kirby

Address: 3048 Woodside Ave

17. Burial (Burial, cremation, or removal, which?) Date thereof: Sept 15 47 (month) (day) (year)

Cemetery or crematory: Parkwood

Location: Taylor Ave

18. Funeral director: L Ideimann & Son

Address: 6067 Harford Rd

19. Sept 15 19 47 (Date rec'd by registrar) C W Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 12, 19 47, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 6 19 , to 19 47

and that I last saw h alive on Sept 10 19 47

Immediate cause of death: Coronary Thrombosis — DURATION

Due to: arteriosclerosis Gen

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E. H. Tomlin M. D. or other

Address: 104 W Madison St Date signed: Sept 15, 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13 t

07802 21

Reg. Dist. No.

1. PLACE OF DEATH:
County Baltimore
City or town Turners Sta Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Turners Sta.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 102 East Ave Dundalk 22 Md
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: RUSSELL S. SCHUYLER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Pauline

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 28, 1908

8. AGE: Years	Months	Days	If less than one day
38	10	5	..... hrs. ..... min.

9. Birthplace: Sparrows Point, Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Bethleham Steel Co.

FATHER 12. Name: Eugene Schuyler

13. Birthplace: Washington, D,C,.

MOTHER 14. Maiden name: Detta Stringfellow

15. Birthplace: Virginia

16. Informant: Eugene Schuyler
Address: 102 East Ave, Dundalk 22, Md,.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-5-47 (month) (day) (year)
Cemetery or crematory: Mt. Calvary Cemetery
Location: Anne Arundel Co, Maryland.

18. Funeral director: William A. Jackson
Address: 916 Penna,. Ave,. Balto, I,

19. 9-4 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 2nd 1947, at 8:05 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 25th 1947, to Sept 2nd 1947
and that I last saw him alive on Sept 2nd 1947

Immediate cause of death	DURATION
Acute Pneumonic Phthisis	1 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: F N Thomas M.D. (M. D. or other)
Address: Turners Sta Md. Date signed 9/3/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

56 ~

07803

CERTIFICATE OF DEATH

Reg. Diat. No. 33

1. PLACE OF DEATH:

County: Baltimore

City or town: Owings Mills

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Deale

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Margaret nmi Sears

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: Wade Hampton Sears

6.(c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr.): 2 October 1870

8. AGE: Years	Months	Days	If less than one day
76 ~~77~~	11	16	hrs. min.

9. Birthplace: Baden, Germany (Town, county, and state)

10. Usual occupation: H.W.

11. Industry or business

FATHER 12. Name: ? Henning

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: ~~Mar~~ ?

MOTHER 15. Birthplace: ?

16. Informant: Mr. Wade H. Sears

Address: Owings Mills Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 20/47 (month) (day) (year)

Cemetery or crematory: Lunatics

Location: Catonsville Md.

18. Funeral director: J. A. Hardesty & Son

Address: Catonsville Md.

19. Sept-18 1947 (Date rec'd by registrar) MARY B. ELine. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 18 Sept. 1947 at 12:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 30 June 1947 to 18 Sept. 1947 and that I last saw h.. alive on 17 Sept. 1947

Immediate cause of death	DURATION
Malnutrition	
Due to: Benign polyp of sigmoid	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Charles H. Williams M. D. M. D. or other

Address: Pikesville 8, Md. Date signed 18 Sept. 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

47
77
18 70

2 Oct.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

Reg. Dist. No. 078133

1. PLACE OF DEATH:
County: Balto.
City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 78 Hanover Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Samuel Edward Shaw

3.(b) Social Security Number: 213-01-5595

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elsa A Shaw
8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 31, 1896

8. AGE: Years	Months	Days	If less than one day
51	1	14	hrs. min.

9. Birthplace: Frederick Md.
(Town, county, and state)
10. Usual occupation: Cashier in Bank
11. Industry or business:
FATHER 12. Name: Samuel Shaw
13. Birthplace: Frederick Co.
MOTHER 14. Maiden name: Olive Null
15. Birthplace: Frederick Co.
18. Informant: Elsa A. Shaw
Address: Reisterstown, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 18, 1947 (month) (day) (year)
Cemetery or crematory: Druid Ridge
Location: Balto. Co.
18. Funeral director: J.F. Eline & Sons
Address: Reisterstown, Md.
19. 9-16-1947 (Date rec'd by registrar) Mary B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 14 19 47, at 11:15 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-13 19 36, to Sept 14 19 47
and that I last saw him alive on Sept 14 19 47

Immediate cause of death	DURATION
Coronary Occlusion	1 3/4 hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: D. D. Caples, M.D. M. D. or other
Address: Reisterstown Md Date signed 9-15-'47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

948

07805

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County: Baltimore

City or town: Owings Mills
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Reisterstown Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Owings Mills
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Reisterstown Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Harry Samuel Simmons Sr.

3.(b) Social Security Number
212-09-8801

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband or~~ wife: Sarah Jane Simmons

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 5th 1897

8. AGE: Years	Months	Days	If less than one day
50	1	15	hrs. min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual occupation: Telegraph Operator

11. Industry or business: B & O R.R.

FATHER
12. Name: Robert G. Simmons
13. Birthplace: Md.

MOTHER
14. Maiden name: Ida M. Martin
15. Birthplace: Md.

16. Informant: Sarah J. Simmons
Address: Owings Mills Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/23/47 (month) (day) (year)

Cemetery or crematory: London Park

Location: Balto. Md.

18. Funeral director: William Cook Inc.

Address: 1217 St. Paul St.

19. 9/22 1947 (Date rec'd by registrar) S. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 20 1947, at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-20-'47 19 to 9-20-'47 19 and that I last saw her alive on not seen alive 19

Immediate cause of death	DURATION
Angina Pectoris	½ hour
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: NONE Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? NONE (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Dr D. D. Eagles, Med. Exam. M. D. or other

Address: Reisterstown, Md. Date signed 9-20-'47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07806

83a

CERTIFICATE OF DEATH

Reg. Diat. No. 32

1. PLACE OF DEATH:

County: Baltimore

City or town: Garrison
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? five years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Garrison
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME LOTTIE F. SIMMONS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Robert F. Simmons

6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): February 2, 1877

8. AGE:	Years	Months	Days	If less than one day
	70	6	15	hrs. min.

9. Birthplace: Baltimore, Maryland (town, county, and state)

10. Usual occupation: housewife

11. Industry or business: home duties

FATHER
12. Name: unknown

13. Birthplace: unknown

MOTHER
14. Maiden name: unknown

15. Birthplace: unknown

16. Informant: Robert F. Simmons

Address: Garrison, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 20, 1947 (month) (day) (year)

Cemetery or crematory: Parkwood Cemetery

Location: Baltimore, Maryland

18. Funeral director: William Cook, Inc.

Address: St. Paul & Preston Sts.

19. 9/17/47 (Date rec'd by registrar) 19 E E Michael, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 17 1947, at 11:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 17 1947, to September 17 1947 and that I last saw her alive on September 17 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	8 hrs.
Due to: Arterial hypertension	?
Due to:	
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E E Michael M.D. M. D. or other

Address: Pikesville 8, Md. Date signed: 9/17/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164a

07807

CERTIFICATE OF DEATH

Reg. Dist. No. 42

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Woodlawn
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Woodlawn Sam
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County:
City or town: Balto Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 1812 Madison st
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: V

3. (a) FULL NAME: John Sisovsky

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Rose Sisovsky
6(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): August 1886

8. AGE: Years	Months	Days	If less than one day
61	2		hrs. min.

8. Birthplace: Hungary (Town, county, and state)
10. Usual occupation: Baker
11. Industry or business:
FATHER 12. Name: Andrew Sisovsky
13. Birthplace: Hungary
MOTHER 14. Maiden name: Madid ?
15. Birthplace: Hungary
16. Informant: Rose Sisovsky
Address: Port Ewin - N.Y.
17. Cremation (Burial, cremation, or removal. Which?) Date thereof 10-6-47 (month) (day) (year)
Cemetery or crematory: London Park Cemetery
Location: Baltimore
18. Funeral director: Edw. J. Marfast
Address: Catonsville - Md
19. Oct 3 1947 (Date rec'd by registrar) Geo. Kieffer (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 29 1947, at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h__ alive on ____ 19__.

Immediate cause of death	DURATION
Strangulation	
Due to Hanging by rope	
Due to from tree	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of: Sept 29 47
Where did injury occur? Woodlawn (City or town) Balto (County) (State)
Injured at home, farm, industry, public place (where?): Public Place
Means of injury: Hanging from tree Injured at work? no

23. SIGNATURE: Geo. McKieffer Deputy Coroner
M. D. or other
Address: 1010 Leadenhall Date signed: Sept 29 47

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore 186a Reg. Dist. No. 43-8

CERTIFICATE OF DEATH

07808

1. PLACE OF DEATH:
(a) County Balto.
(b) City or town Baltimore 14 (Hamilton) (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: 2515 E. Joppa Rd.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 11 mos.

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto 14. Hamilton P.O. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2515 E. Joppa Rd. (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

3 (a) **FULL NAME** Eugene Thomas Smith

3 (b) If veteran, name war: None
3 (c) Social Security No. None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8/1943

8. **AGE:** Years 4 | Months 2 | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name Charles J. Smith
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Rita C. Kernan
15. Birthplace Baltimore, Md.

16 (a) Informant Charles J. Smith
(b) Address 2515 E. Joppa Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Avenue Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) 9/10/47 (Date rec'd by registrar) (b) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. Date of death Sept. 10 1947 at 2.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____, and that I last saw him alive on ____ 19____.

	Duration
Immediate cause of death Concussion of Brain	Sept 7/47
Due to Fall down cellar step	
Due to Cerebral Hemorrhage	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 9/2/47
(c) Where did injury occur? Balto 14, (City or town) Balto (County) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? At home (Specify type of place) While at work? Play
(e) Means of injury Fall down cellar step

23. Signature J. M. Carmine M.D. (M. D. or other)
Address Randallstown MD Date signed 9/10/47.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 07809 (30)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Balto.

City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Hood Nursing Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Balto.

City or town Balto. (If outside city or town limits, write RURAL and give nearest town)

Street No. 2210 Roslyn Ave. (If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME GORDON SMITH

3.(b) Social Security Number 216-05-6366

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Elsie C. Smith

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1877

8. AGE: Years	Months	Days	If less than one day
70	0	18	..... hrs. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual occupation Salesman

11. Industry or business Wardell Fuel Co.

FATHER 12. Name John Kilty Smith

13. Birthplace Md.

MOTHER 14. Maiden name Janet Goodwin

15. Birthplace Md.

16. Informant Mrs. Elsie C. Smith

Address 2210 Roslyn Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/30/47 (month) (day) (year)

Cemetery Greenmount Cem.

Location Balto. Md.

18. Funeral director WM. J. TICKNER & SONS INC.

Address North & Pa. Aves. Balto. 17, Md.

19. 9-30 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Sept. 27, 1947 at 6:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 1947 to Sept 27 1947

and that I last saw h... alive on Sept 27 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	7 days
Due to Arterio Sclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James Stowell M. D. or other

Address Date signed 9-29

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

462

07810

Reg. Dist. No. 44

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 90 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 90 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1308 W. Mulberry Street

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3. (a) FULL NAME: JESSIE SMITH

3. (b) Social Security Number: 219-20-7696

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	colored	married

6.(b) Name of husband or wife: ~~////~~ Rebecca Smith

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 3-4-1887

8. AGE: Years	Months	Days	If less than one day
60	6	5	hrs. min.

9. Birthplace: South Hill, Va. (Town, county, and state)

10. Usual occupation: Unemployed

11. Indusfry or business:

FATHER — 12. Name: Philip Smith; 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Eliza Jones; 15. Birthplace: Virginia

16. Informant: Clinical Records, Vets. Adm. Hosp. Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal, which) Date thereof: Sept 13. 47 (month) (day) (year)

Cemetery or crematory: Balto. National Cem

Location: Baltimore Md

18. Funeral director: Elroy O. Wilson

Address: 1008 Bentley ave

19. 9/10 1947 (Date rec'd by registrar) A.W. Tedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 9, 1947, at 5:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 11, 1947, to September 9, 1947 and that I last saw him alive on September 9, 1947

Immediate cause of death: Carcinoma of the Caecum Metastatic to Liver and Mesentery — DURATION: 18 mos. Plus

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison M. D. or other

R.M.CULLISON, MD. CLIN. DIR.

Address: V.A.H. Fort Howard, Md. Date signed: 9-9-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

07812

CERTIFICATE OF DEATH

Reg. Diat. No. 31

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 mos. 29 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 9 mos. 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Mt. Rainier

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4224 31st. Street

(If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME: SOUSSA, Mary Elizabeth

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Deceased.

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Unknown. 1867

8. AGE: Years: 80 (?) Months: Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: Unknown. (Town, county, and state)

10. Usual occupation: Unknown.

11. Industry or business: Unknown.

FATHER

12. Name: Unknown.

13. Birthplace: Unknown.

MOTHER

14. Maiden name: Unknown.

15. Birthplace: Unknown.

16. Informant: Hospital Records.

Address: Spring Grove State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 22 1947 (month) (day) (year)

Cemetery or crematory: Mt Olivet Cemetery

Location: Washington, D.C.

18. Funeral director: T. F. Costello

Address: 1722 North Capitol St

19. 10/23 (Date rec'd by registrar) 1947 A.W. Hedrich per Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 13, 1947, at 10:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 15, 1946 to September 13 1947 and that I last saw her alive on September 13, 1947

Immediate cause of death	DURATION
Acute cardiac failure; Chronic cardiac asthma; Chronic cardiovascular disease.	Indefinite
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Isadore Tuerk, M. D. M. D. or other

Address: Spring Grove State Hospital Date signed: 10-22-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information correctly. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

COPY SENT TO CHO REGISTRAR NO. DATE 10/22/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

830 07813

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 yrs
Hospital, institution, or street address where death occurred: Dellvue Lane
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)
Street No.: Dellvue Lane (If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Anthony Peter Stromberg

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Mary Ellen Stromberg
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Oct 8, 1854

8. AGE: Years	Months	Days	If less than one day
92	11	3	..... hrs. ..... min.

9. Birthplace: Elkridge Landing, Md. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Retired
FATHER 12. Name: William Stromberg
FATHER 13. Birthplace: Germany
MOTHER 14. Maiden name: Christina Gundeau
MOTHER 15. Birthplace: Germany
16. Informant: Henry M. Stromberg
Address: Catonsville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 15 (month) (day) 1947 (year)
Cemetery or crematory: St Louis Cemetery
Location: Clarksville, Md
18. Funeral director: Easton Sons
Address: 608 Frederick Ave Catons Md
19. Sept 14 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 11, 1947, at 11:45 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 1 1947 to Sept 11 1947
and that I last saw h.. alive on Sept 11 1947
Immediate cause of death: Cerebral Hemorrhage — DURATION: 2 days
Due to: Generalized Arteriosclerosis
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operation: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Catonsville Md Date signed: 9-12

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48b

07814

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
524 Park Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 7121 Harford Road
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: ALVINA STUMPF

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John Stumpf
6.(c) If alive, give age: 85? years

7. Birth date of deceased (mo., day, yr.): September 26, 1866

8. AGE: Years	Months	Days	If less than one day
80	11	24	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: Peter Kolb
13. Birthplace: Germany

MOTHER
14. Maiden name: Augusta Rudiger
15. Birthplace: Germany

16. Informant: Mrs. C.C.Ferril
Address: 524 Park Ave., Towson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 22, 1947 (month) (day) (year)
Cemetery or crematory: Loudon Park Cemetery
Location: Baltimore, Maryland

18. Funeral director: John Burns' Sons
Address: Towson, Maryland

19. Sept 22 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION E. ST. T.

20. DATE OF DEATH: Sept 19 1947 at 1:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 4 1947 to Sept 19 1947 and that I last saw h.. alive on Sept 19 1947

Immediate cause of death	DURATION
Carcinoma of Uterus	3 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. C. Sellman M.D. M. D. or other
Address: Towson Md Date signed: Sept 19, 1947

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07815

488

CERTIFICATE OF DEATH

Reg. Diat. No. 39

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months, 17 days
Hospital, Institution, or street address where death occurred:
Sheppard-Pratt Hospital, Employee's Infirmary
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Rural (Towson)
(If outside city or town limits, write RURAL and give nearest town)
Street No. Sheppard-Pratt Hospital
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: MRS. MARION BURNETT STURTZ

3. (b) Social Security Number: 218-16-4165

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife: John W. Sturtz (Mt. Savage, Md.)
6.(c) If alive, give age: unkown years
7. Birth date of deceased (mo., day, yr.): February 6, 1886

8. AGE: Years	Months	Days	If less than one day
61	7	6	....hrs. ....min.

9. Birthplace: Lanarkshire, Scotland (Town, county, and state)
10. Usual occupation: Maid
11. Industry or business: Sheppard-Pratt Hospital

FATHER
12. Name: George Burnett
13. Birthplace: Lanarkshire, Scotland

MOTHER
14. Maiden name: Isabella Leird
15. Birthplace: Lanarkshire, Scotland

16. Informant: Records of Woman's Hospital
Address: Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 15, 1947 (month) (day) (year)
Cemetery or crematory: Prospect Hill Cemetery
Location: Towson, Maryland
18. Funeral director: John Burns' Sons
Address: Towson, Maryland
19. Sept 15 1947 (Date rec'd by registrar) W E Fawthrop Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 12 19 47 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 27 19 46 to Sept. 12 19 47 and that I last saw her alive on September 12 19 47

Immediate cause of death	DURATION
(auricular fibrillation)	1 day
Due to: Arteriosclerosis and hypertensive cardiovascular disease	unknown
Due to:	
Other conditions: Recurrence of carcinoma in pelvic lymph nodes & bladder. Anemia.	1 year

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of uterus with extension & metastases Date of op. July 30, 1946
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Charles Ferris M.D. M. D. or other
Address: Sheppard-Pratt Hospital Date signed: 9-12-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07816

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 years, 5 months, 7 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 34 years, 5 months, 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: ?

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: William Tolkin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: –

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1892?

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
55	?	?		

9. Birthplace: Russia (Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER 12. Name: Himan Tolkin

FATHER 13. Birthplace: Russia

MOTHER 14. Maiden name: Eva Levitt

MOTHER 15. Birthplace: Russia

16. Informant: Hospital records

Address: Catonsville-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 9/47 (month) (day) (year)

Cemetery or crematory: Washington Blvd

Location:

18. Funeral director: Sol Levinson & Bros.

Address: 1124-26 W North Ave.

19. 9/8/47 (Date rec'd by registrar) 19 [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 7 19 47 at 7:05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ..., to ... 19 ...

and that I last saw h... alive on ... 19 ...

Immediate cause of death	DURATION
Acute Cardiac failure	
Due to: Cardio Vascular disease	
Other conditions: sudden death	
(Include pregnancy within 3 months of death) Inquest	

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Geo S Mukiffer Deputized Evelyn T Ball M. D. or other

Address: 1010 Leadenhall Date signed: Sept 8, 47

Nonmetallic

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07817

Reg. Dist. No. 47

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred: Vets. Adm. Hosp. Fort Howard, Md.
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2511 Guilford Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: SAW

3. (a) FULL NAME: HENRY JOHN TRIMP

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male M	White	Married

6.(b) Name of husband or wife: Mary Trimp
6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): February 18, 1879

8. AGE: Years	Months	Days	If less than one day
68	6	21	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: Deceased Henry J. Trimp
13. Birthplace: Md

MOTHER — 14. Maiden name: Deceased Jane Kilroe
15. Birthplace: Md.

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9/10/47 (month) (day) (year)
Cemetery or crematory: Cathedral Cemetery
Location: Baltimore, Maryland

18. Funeral director: Wm. Cook Inc.
Address: St. Paul at Preston Sts.

19. 9/8 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 7, 1947, at 2:20 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 4, 1947, to September 7, 1947 and that I last saw him alive on September 7, 1947

Immediate cause of death	DURATION
CARDIAC DILATATION	?
Due to: Aneurysm of abdominal aorta and aneurysm of right renal artery	?
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results: Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Gabriel F. Cuccia, M.D.
Address: VA Hospital M. D. or other
Date signed: Sept 7, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

BC 13C 07818 6

Reg. Diat. No. 44

1. PLACE OF DEATH:
County Baltimore
City or town Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 230 days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Fort Howard, Md.
How long in hospital or institution? 230 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 704 N. Mount Street Balto. 17, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war WW II

3.(a) FULL NAME
WILLIAM F. TUCKER

3.(b) Social Security Number
103-30-6975

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife Marie F. Tucker
6.(c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) July 17, 1908

8. AGE: Years	Months	Days	If less than one day
39	1	28	....hrs. ....min.

9. Birthplace Rocky Mt. North Carolina
(Town, county, and state)
10. Usual occupation Cook
11. Industry or business

FATHER
12. Name Rupert Tucker
13. Birthplace West Virginia

MOTHER
14. Maiden name Mary E. Hines
15. Birthplace North Carolina

16. Informant Clinical Records Vet. Adm. Hosp.
Address Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 17-47 (month) (day) (year)
Cemetery or crematory Social Union
Location Rocky Mountain, North Carolina

18. Funeral director Elroy Wilson
Address 1000 Brently Avenue Balto. Maryland

19. Sept 15 47 (Date received by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 14 1947 at 1:15 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 26 1947 to September 14 47 and that I last saw him alive on September 14 47

Immediate cause of death	DURATION
TUBERCULOSIS, PULMONARY, BILATERAL, FAR ADVANCED	8 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ....Date of op. ....
Autopsy results ....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide .... Date of ....
Where did injury occur? .... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury .... Injured at work?

23. SIGNATURE Robert M. Cullison
R. M. CULLISON, M.D. Clinical Director
Address V.A. Hosp. Fort Howard, Md. Date signed 9/14/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07819

930

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Randallstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 37 yrs.
Hospital, institution, or street address where death occurred:
Cliffmar Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Randallstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Cliffmar Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: George Clayton Tull

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Ella Tull
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 16, 1868

8. AGE: Years	Months	Days	If less than one day
79	5	20	..... hrs. ..... min.

9. Birthplace: Accomock Co., Virginia
(Town, county, and state)
10. Usual occupation: Merchant (Retired)
11. Industry or business

FATHER
12. Name: Unknown, Virginia
13. Birthplace

MOTHER
14. Maiden name: Unknown - Virginia
15. Birthplace

16. Informant: Mr. Harold White
Address: Cliffmar Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-8-47 (month) (day) (year)
Cemetery or crematory: Downing Church Cemetery
Location: Cockeysville Md
18. Funeral director: Frank H Newell
Address: Pikesville R. md.

19. 9-6-47 (Date rec'd by registrar) E.E. Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 5, 1947, at 9:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 19, 1947 to Sept. 6 1947 and that I last saw him alive on Sept. 5, 1947

Immediate cause of death	DURATION
Coronary occlusion	Sudden
Due to: Chronic Myocarditis	7
Due to: Arterio Sclerosis	7
Due to:	
Other conditions: Senility	-

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Dr E.E. Nichols M. D. or other
Address: Pikesville, Md. Date signed: 9-6-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

07820

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH

County: Baltimore

City or town: Bare Hills

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year (at work)

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Pikesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Stablerville Rd

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME George Washington Turnbaugh

3. (b) Social Security Number 917-07-6366

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Alice Palmer Turnbaugh. 6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): August 1, 1879

8. AGE: Years: 68 Months: 1 Days: 2 If less than one day: ..... hrs. ..... min.

9. Birthplace: Black Rock, Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Track Gang P.R.R.

FATHER — 12. Name: Richard Turnbaugh.

13. Birthplace: Unk.

MOTHER — 14. Maiden name: Ellen Shaw

15. Birthplace: Alesia, Md.

16. Informant: Mrs. Alice Turnbaugh

Address: Parkton, Md. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 6, 1947. (month) (day) (year)

Cemetery or crematory: Mt. Zion Cemetery

Location: Freeland, Balto. Co., Md.

18. Funeral director: Jacob Hartenstein

Address: New Freedom, Pa.

19. 9-4-47 (Date rec'd by registrar) E.E. Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 3 1947 at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death: Hemitaluscence pneumonia — DURATION 9/3/47

Coronary Occlusion sudden

Due to: .....

Due to: .....

Other conditions: .....

(Include pregnancy within 3 months of death)

Major findings of operation: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Rollin L. Hudson M.D. D.M.E. M. D. or owner

Address: Towson Md. Date signed: 9/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

930

07821

Reg. Dist. No. 32

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

1. PLACE OF DEATH:
County: Baltimore
City or town: Rural, McDonogh Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs.
Hospital, institution, or street address where death occurred: McDonogh, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Baltimore
City or town: Rural, McDonogh, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Electa Anderson Wallace

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	widowed

6.(b) Name of husband or wife: James A Wallace
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Dec 23, 1869

8. AGE: Years	Months	Days	If less than one day
77	8	17	hrs. min.

9. Birthplace: Jamestown, Pa. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: —

FATHER
12. Name: John Anderson
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Jane McCurdy
15. Birthplace: Pennsylvania

18. Informant: Mrs. William Gaswell
Address: McDonogh, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/8/47 (month) (day) (year)
Cemetery or ~~crematory~~: Rocky Glen
Location: Adamsville, Pa.
18. Funeral director: John O. Mitchell & Sons, Inc.
Address: 1900 Eutaw Place, Balto, Md.

19. 9/8/47 (Date rec'd by registrar) E E Mehrl Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5 Sept 1947, at 4:47 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947, to 5 Sept 1947 and that I last saw her alive on 5 Sept 1947

	DURATION
Immediate cause of death: Cardiorespiratory failure	2 hrs.
Due to: Bronchopneumonia	3 days
Due to: ~~Cystic~~ Hypertensive cardiovascular Disease	10 yrs.
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Paul V Royal M.D. (M. D. or other)
Address: 211 Church Lane Pikesville 8 Md. (Date signed) Sept 9 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07822   94a

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
County: Balto
City or town: Middle River P.O. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Bx 234 Chester ave
How long in hospital or institution? Long Beach. 11 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State   County
City or town: Same (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Bernard F. Weinhold.

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widower
6.(b) Name of husband or wife: Susanna.
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): June 14, 1872

8. AGE: Years 75   Months 3   Days 4   If less than one day ... hrs. ... min.

9. Birthplace: Maryland, Balto. City (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Standard Oil Co.

FATHER
12. Name: Henry
13. Birthplace: Balto. md.

MOTHER
14. Maiden name: anna Polcof.
15. Birthplace: md.

16. Informant: Bernard F. Weinhold.
Address: above.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/22/47 (month) (day) (year)
Cemetery or crematory: Sacred Heart of Mary
Location: German Hill Rd

18. Funeral director: Clarence F. Hoffman
Address: 1639 Broadway

19. 9/19/47 (Date rec'd by registrar)   A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 18 1947, at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 18 1947, to — 19
and that I last saw h... alive on ... 19

Immediate cause of death: Coronary Disease   DURATION: Immediate.
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: M. McCormick M.D. (M.D. or other) Deputy Medical Examiner
Address: Dundalk 22   Date signed 9/18/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15   9-45-15M

(I)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07823

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo. 22 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 1 mo. 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 310 S. Broadway

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: KATTIE CHLOPICKA - WELZEL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Separated

6.(b) Name of husband or wife: Howard Welzel

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Oct 16 1908

8. AGE: Years	Months	Days	If less than one day
38	10	25	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Domestic

FATHER — 12. Name: John Chlopicki

FATHER — 13. Birthplace: Poland

MOTHER — 14. Maiden name: Josephine Rundy

MOTHER — 15. Birthplace: Poland

16. Informant: Bertha Ey

Address: 3108. Broadway

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept-29-47 (month) (day) (year)

Cemetery or crematory: Holy Rosary

Location: Balto. Co.

18. Funeral director: Wm. S. Fialkowski

Address: 2007 Eastern Ave

19. 9-25-47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 23 19 47, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1 19 47, to Sept. 23 19 47

and that I last saw her alive on September 23 19 47

Immediate cause of death	DURATION
Acute myocardial failure;	1 day
C. N. S. lues	years
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Isadore Turk M.D.

M. D. or other

Address: Spring Grove State Hospital Date signed: 9-23-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information (including the correct age if unknown). This is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61

07824

Reg. Dist. No. 34

1. PLACE OF DEATH:
County Baltimore
City or town Trenton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Balto
City or town Trenton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lizzie M Wheeler

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife Elisha P Wheeler
6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) November 17-1884

8. AGE:

Years	Months	Days	If less than one day
62	10	9	hrs. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Jacob Rupp
13. Birthplace Md

MOTHER
14. Maiden name Sarah Wentz
15. Birthplace Md

16. Informant Elisha P Wheeler
Address Upperco Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 29/47 (month) (day) (year)
Cemetery or crematory Grace
Location Balto Co Md
18. Funeral director Edward A Tipton
Address Hampstead Md

19. Sept 27 1947 (Date rec'd by registrar) Cyril E. Fowth M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 26 1947, at 5:30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946, to Sept. 26 1947 and that I last saw h alive on Sept. 21 1947

Immediate cause of death	DURATION
Coronary artery Disease	18 mo
Due to	
Due to	
Other conditions Diabetes Mellitus	5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Maurice C. Canfield M. D. or other
Address Hampstead Md Date signed 9-26-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

07825

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Balto County
City or town: Essex
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto
City or town: Essex R 4
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1500 Eastern Ave Rd
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Margaret Augusta Wilk

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: George

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 5-1866

8. AGE: Years: 81 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business:

FATHER
12. Name: Frank Schneider
13. Birthplace: Germany

MOTHER
14. Maiden name: Anna Betz
15. Birthplace: Germany

16. Informant: George Wilk
Address: 1500 Eastern Ave Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-30-47 (month) (day) (year)
Cemetery or crematory: Sacred Heart
Location: German Hall Rd.

18. Funeral director: J. J. Brandemuhl
Address: 1467 Eastern Ave Rd

19. 9-29 19 47 (Date rec'd by registrar) J. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 26 19 47, at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 19 47 to Sept 26 19 47 and that I last saw her alive on Sept 26 19 47

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden
Due to Arterio-Sclerotic-Cardio-Vascular disease	1 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Geo. M. Baumgardner M. D. or other
Address: Balto 6 Date signed: 9-26-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Bc 111a

07826

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Fort Howard, Md.
How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 772 Waescher Streets.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-1

3.(a) FULL NAME: BERLIN L. WILLIAMS

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Mary Williams
6.(c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): August 18, 1895

8. AGE: Years	Months	Days	If less than one day
52	0	25	....hrs. ....min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business:

FATHER
12. Name: Abner Williams
13. Birthplace: Oklahoma

MOTHER
14. Maiden name: Julia Woolford
15. Birthplace: Texas

16. Informant: Clinical Records Vet. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: 9-17-47 (month) (day) (year)
Cemetery or crematory: Balts. National
Location:

18. Funeral director: Adolphus Halstead
Address: 918 Druid Hill Avenue

19. Sept 16 1947 (Date rec'd by registrar) A. W. Hobbs Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 13 1947 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 28 1947 to Sept. 13 1947 and that I last saw him alive on September 13 1947

Immediate cause of death	DURATION
INFARCTS, RIGHT AND LEFT LUNGS	Unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ....Date of op.:

Autopsy results: Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison
ROBERT M. CULLISON, M.D. Clinical Director
Address: Vets. Adm. Hosp. Fort Howard, Md. Date signed: 9-14-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a 07827

Reg. Dist. No. 33

1. PLACE OF DEATH:

County: Balto.

City or town: Glyndon (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Balto

City or town: Glyndon (If outside city or town limits, write RURAL and give nearest town)

Street No. 32 Sacred Heart Lane (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Margaret Emma Williams

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife: John Williams

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 11, 1886

8. AGE: Years	Months	Days	If less than one day
61		3	..... hrs. ..... min.

9. Birthplace: Carroll Co. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER — 12. Name: John Robinson; 13. Birthplace: Md.

MOTHER — 14. Maiden name: Cassanda Nelson; 15. Birthplace: Md.

16. Informant: Hilda Jorden

Address: Reisterstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 16, 1947 (month) (day) (year)

Cemetery or crematory: Piney Grove

Location: Balto. Co.

18. Funeral director: J. F. Eline & Sons

Address: Reisterstown, Md.

19. 9-16-47 (Date rec'd by registrar) Mary B. Eline. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 14, 19 47, at 9 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 6-20, 19 37, to Sept 14, 19 47, and that I last saw h.er alive on Sept 8, 19 47

Immediate cause of death	DURATION
Coronary Occlusion	10 min
Due to	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: D. D. Eaples, M. D. M. D. or other

Address: Reisterstown, Md. Date signed: 9-15-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07828 Reg. Dist. No. 43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Baltimore
City or town Fullerton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 week
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Loch Raven (If outside city or town limits, write RURAL and give nearest town)
Street No. Box 355 Maryland Training School for Boys (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Joshua Robey Wilson
3.(b) Social Security Number

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Lydia Elizabeth Wilson
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) December 31- 1889
8. AGE: Years 57 Months 8 Days 15 If less than one day ... hrs. ... min.
9. Birthplace Carroll Co Maryland (Town, county, and state)
10. Usual occupation Cottage Master
11. Industry or business Maryland Training School for Boys
FATHER 12. Name Louis T. Wilson
13. Birthplace Maryland
MOTHER 14. Maiden name Keziah E. Barnes
15. Birthplace Maryland
16. Informant Mrs. Lydia E. Wilson
Address Box 355 Loch Raven Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 18-1947 (month) (day) (year)
Cemetery or crematory Providence
Location Gamber, Carroll Co. Maryland
18. Funeral director Burgee Funeral Home
Address 3631 Falls Road Baltimore 11
19. Sept 17 1947 (date received by registrar) A. H. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 15- 1947 at 2 55 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 1947 to September 15 1947
and that I last saw him alive on September 13 1947

	DURATION
Immediate cause of death: anorexia	3 weeks
Due to: Pulmonary Tuberculosis	3 Months
Due to: Chronic Myocarditis	5 Months
Other conditions: arteriosclerosis (Include pregnancy within 3 months of death)	1 year

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Egbert H. Mortimer Jr. Md M. D. or other
Address 2706 St Paul St Date signed 9/16/47

VS A15 9-45-15M

(I)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1246 07829

CERTIFICATE OF DEATH

Reg. Dist. No. 47

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 32 days

Hospital, Institution, or street address where death occurred:

VAH Fort Howard, Maryland

How long in hospital or Institution? 32 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 614 Venable Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: WW II ✓

3.(a) FULL NAME: CALVIN F. WOLF (CALVIN FRANKLIN WOLF)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: ////// Emma Wolf

6.(c) If alive, give age: 31 years

7. Birth date of deceased (mo., day, yr.): 10-4-10

8. AGE: Years	Months	Days	If less than one day
36	11	11	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER — 12. Name: Louis Wolf

13. Birthplace: Baltimore, Md.

MOTHER — 14. Maiden name: Lydia Ford

15. Birthplace: Baltimore, Md.

16. Informant: Clinical Records, Vets Adm. Hosp.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/18/47 (month) (day) (year)

Cemetery or crematory: Baltimore Cem.

Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. Sept 17 19 47 (Date rec'd by registrar) A. W. Hesbrook Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 15 19 47 at 6:26 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 14 19 47 to September 15 19 47 and that I last saw him alive on September 15 19 47

Immediate cause of death	DURATION
PORTAL CIRRHOSIS	1 month plus
Due to	
Due to	
Other conditions: Splenomegaly, XXXXXXXXX	unknown
Spontaneous Pneumothorax	unknown

(Include pregnancy within 3 months of death)

Major findings of operations: Hobnail liver and enlarged Spleen Date of op. 9-4-47

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Brian Olin, M.D. M. D. or other

Address: V.A.H. Fort Howard, Md. Date signed: 9-15-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92a

07830

CERTIFICATE OF DEATH

Reg. Dist. No. 43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Balto.

City or town: Raspeburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:
Whitemarsh Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Raspeburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Whitemarsh Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: GEORGE J. WOLF

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Louise Wolf

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 28th, 1879

8. AGE: Years	Months	Days	If less than one day
68	1	21	..... hrs. ..... min.

9. Birthplace: Balto. Co., Md.
(Town, county, and state)

10. Usual occupation: Truck Farmer

11. Industry or business

FATHER
12. Name: Geo. M. Wolf
13. Birthplace: Germany

MOTHER
14. Maiden name: Fredericka Bogt
15. Birthplace: Germany

16. Informant: Mr. Thos. W. Wolf,
Address: Whitemarsh Rd., Raspeburg, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 23, 1947 (month) (day) (year)

Cemetery or crematory: Parkwood

Location: Balto., Md.

18. Funeral director: Lasahn Funeral Home

Address: 7401 Belair Road

19. Sept 21 (Date rec'd by registrar) 19 47 Mrs. Gale Reynolds Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 19th, 1947 at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17 1947, to June 13 1947 and that I last saw h...m alive on June 13 1947.

	DURATION
Immediate cause of death: Coronary thrombosis	?
Due to: Hypertensive arteriosclerotic cardiovascular disease	5 yrs
Due to:	
Other conditions: Gen'l Arteriosclerosis	5 yrs
Calcific aortic stenosis	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: K. R. Yellen M.D.
M. D. or other

Address: Raps. Rd, Balt-6 Date signed: 9/20/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

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07831

44

Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M) (I) VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 Days

Hospital, Institution, or street address where death occurred:

Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 8 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: .....

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1704 W. Lanvale Street

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I ✓

3. (a) FULL NAME: ROBERT A WOODS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: ////// Bessie Woods

6.(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): 8-24-96

8. AGE: Years	Months	Days	If less than one day
51	0	27	.....hrs. .....min.

9. Birthplace: Kingstree, South Carolina (Town, county, and state)

10. Usual occupation: Longshoreman

11. Industry or business

FATHER — 12. Name: Augustus Woods

13. Birthplace: South Carolina

MOTHER — 14. Maiden name: Eugenia Burgess

15. Birthplace: South Carolina

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/25/47 (month) (day) (year)

Cemetery or crematory: Arbutus

Location: Md.

18. Funeral director: Geo. W. Kelsay

Address: 1303 Presstman St.

19. 9/23 1947 (Date rec'd by registrar) H. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 22, 1947 at 3:35 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 13, 1947, to September 22 1947 and that I last saw him alive on September 22, 1947

Immediate cause of death: Generalized Carcinomatosis. — DURATION: 2 Mos.

Primary site undet. — plus.

Due to.....

Due to.....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. .....

Autopsy results: Substantiated Above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: M. E. McMillan

M. E. McMillan, M. D. M. D. or other

Address V.A.H. FORT HOWARD, MD. Date signed 9-22-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

07832

CERTIFICATE OF DEATH

Reg. Dist. No. 35-

1. PLACE OF DEATH:

County: Baltimore

City or town: Stone

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: White Hall R.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Rosa E. Wright

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Harry J. Wright

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 20 1894

8. AGE: Years: 7 | Months: 6 | Days: 28 | If less than one day: ..... hrs. ..... min.

9. Birthplace: White Hall Co Md

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Housekeeping

FATHER

12. Name: John E. Eddie

13. Birthplace: White Hall Md

MOTHER

14. Maiden name: Mary E. Hutchins

15. Birthplace: Monrille, Md

16. Informant: Leland Wright

Address: White Hall Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof Sept 21 1947 (month) (day) (year)

Cemetery or crematory: Mt. Lebanon

Location: Stone Md

18. Funeral director: W. Howard Hutt

Address: Fawn Grove Pa

19. Sept 19 1947 (Date rec'd by registrar) Charles L. Fuller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 18 1947, at 10:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943, to Sept. 18 1947

and that I last saw h... alive on Sept. 17 1947

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to	
Due to	
Other conditions: Hypertension	

(Includn pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: A. M. France M. D. or other

Address: Parkton, Md. Date signed: 9/19/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d S 07833

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: BALTIMORE
City or town: TOWSON
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
SHEPPARD AND ENOCH PRATT HOSPITAL
How long in hospital or institution? 3 months, 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Dist. of Columbia County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Hotel Roosevelt
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: HELEN MESSER YOUNG

3.(b) Social Security Number: 577-01-6639

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: John Van Doren Young
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 30, 1880

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
66	10	5		

9. Birthplace: Philadelphia, Pa.
(Town, county, and state)
10. Usual occupation: Buyer (Women's clothing)
11. Industry or business: Department store

FATHER
12. Name: William Messer
13. Birthplace: Hawick, Scotland

MOTHER
14. Maiden name: Charlotte Taylor
15. Birthplace: Edinburgh, Scotland

16. Informant: HOSPITAL RECORDS
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 8, 1947 (month) (day) (year)
Cemetery or crematory: Congressional Cemetery
Location: Washington D.C.
18. Funeral director: J. H. Lee
Address: Massachusetts Ave. Wash. D.C.
19. Sept 5 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 5 1947 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 29 1947, to Sept. 5 1947 and that I last saw her alive on Sept. 4 1947

Immediate cause of death	DURATION
Chr. myocarditis & myocardial degeneration	Unk.
Due to: Arteriosclerosis	Unk.
Due to:	
Other conditions: Manic depressive depressed Psychosis	1 yr

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Confirm above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Harry M. Murdock
Harry M. Murdock, M.D. M. D. or other
Address: Towson 4, Md. Date signed: 9/5/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15